SAVE THE CHILDREN/US

NEPAL FIELD OFFICE
CHILD SURVIVAL 8
MIDTERM EVALUATION REPORT

AUGUST 1994

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Glossary

AIDS	Acquired Immune Deficiency Syndrome
AmFAR	American Foundation for AIDS Research
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infections
BPEP	Basic Primary Education Project
BCG	Bacille Calman Guerin
CDD	Control of Diarrhea1 Disease
CD0	Chief District Officer
C-TO-C	Child to Child
CMA	Community Medical Auxiliary
CHV	Community Health Volunteer
CRS	Contraceptive Retail Sales
DE0	District Education Officer
DHO	District Health Officer
DIP	Detailed Implementation Plan
DISVI	Disarmo e Svillupo
DPT	Diphtheria, Pertussis, Tetanus vaccine
ECD	Early Childhood Development
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussions
FP	Family Planning
HBCCC	Home Based Child Care Centre
HIV	Human Immunodeficiency Virus
IANSC	Impact area NGO Strengthening Committee
IEC	Information, Education and Communication
IOM	Institute of Medicine
JJ	Jeevan Jal (oral rehydration salts)
LDO	Local Development Officer
LGM	Learner Generated Materials
MCH	Maternal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NFE	Non-formal education
NFO	Save the Children/ US Nepal Field Office
NGO	Non-Government Organisation
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
o s c	Out of School Classes
PE	Parenting Education
PHC	Primary Health Care
Rs.	Rupees (Nepalese currency)
SCIDB	Small Cottage Industry Development Board
SC/US	Save the Children US
STD	Sexually Transmitted Diseases
TBA	Traditional Birth Attendant
TT	Tetanus toxoid
VDC	Village Development Committee
VHW	Village Health Worker
WDC	Women's Development Coordinator
WOREC	Women's Rehabilitation Centre
WSG	Women's Saving Group

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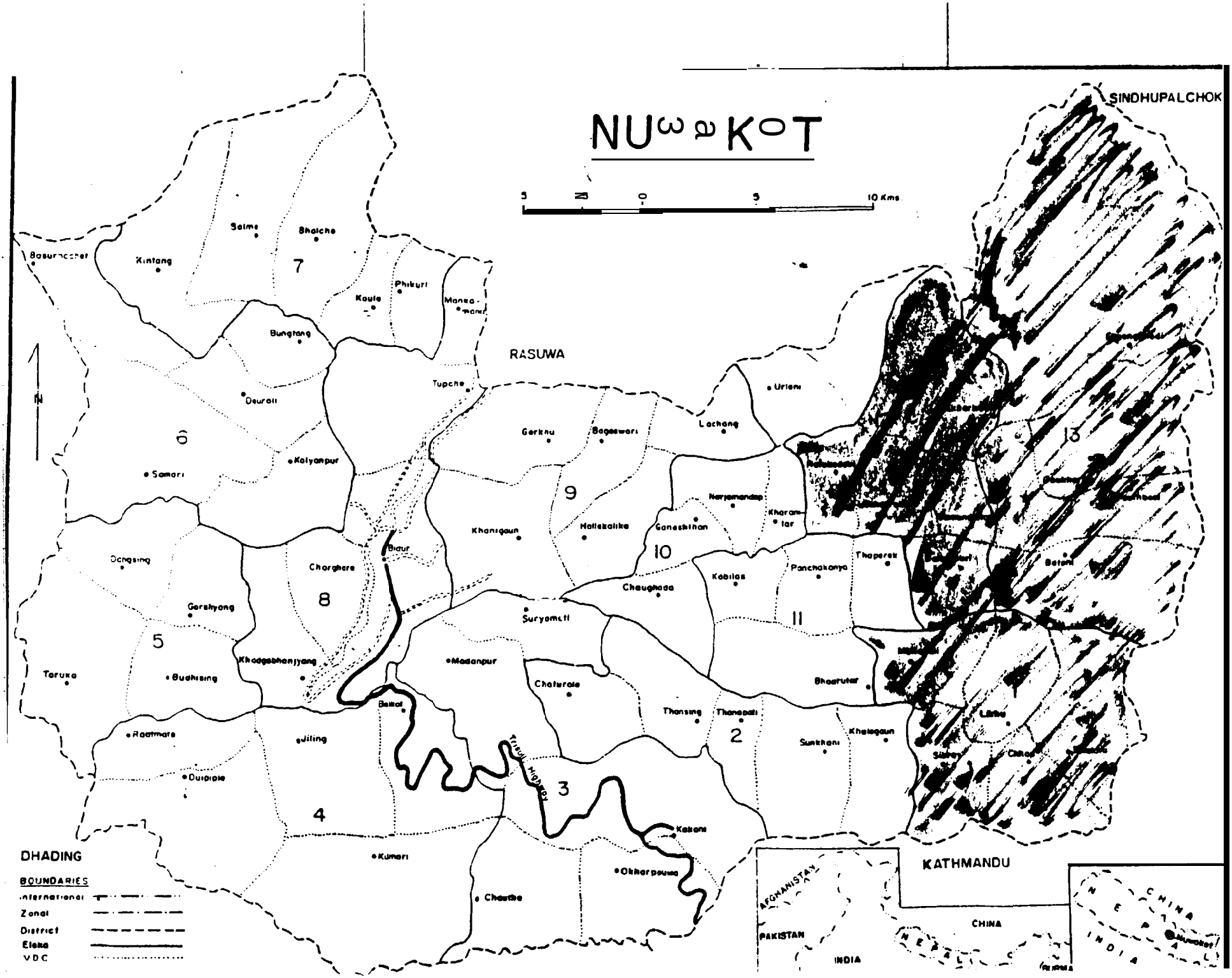

Map of Project Area

Executive Summary

The Evaluation Team had five members: Dr Pathak, Regional Medical Director, Central Region, Nepal; Sharada Pandey, Chief of the Child Health Section, Ministry of Health, Nepal; Kim Wylie, Asia Region Desk Officer, Save the Children/US, Head Office, Westport, USA; Naramaya Lirnbu, Deputy Public Health Coordinator, SC/US Nepal Field Office; and Carrie Osborne, Primary Health Care Consultant, UK (Team Leader). (See Appendix 1 for brief Biodata of the Team members, Appendix 2 for the Objectives for the MTE).

The visit lasted 13 days: 8 days field visits in the project area and 5 days in Kathmandu. (See Appendix 3 for the MTE Team Itinerary). The total cost of the MTE was $5649.67 plus the cost of the Mid Term Cluster Survey of $4043.

The MTE Team held focused interviews with 40 community people, 6 political leaders, 15 project and MOH field staff, 4 district officials, and 8 Kathmandu-based SC/US managers. The Team observed 10 field activities such as non-formal education classes, child-to-child classes, out-of-school classes and a mobile clinic. The Team examined the project DIP, quarterly and annual reports, survey reports, training curricula and IEC materials. (See Appendix 4 for a list of people interviewed and activities observed, Appendix 5 for a list of documents reviewed).

The project team are to be congratulated in achieving many accomplishments in this complex project given the low baseline indicators and the very difficult terrain: a remarkable number of community volunteers, non-formal education facilitators, supervisors, teachers and health staff have been trained in child survival related issues. Many community groups have been formed and are functioning. There is an increased awareness and use of ORT, increased recognition and referral of children with ARI. There is an increase in the number of children receiving Vitamin A supplementation, mothers receiving prenatal care, mothers and children receiving immunisation, and adults receiving education and treatment for STD and HIV/AIDS. The project underestimated how long it would take to start up activities in an isolated area with a very conservative community. The staff are hard-working and committed and are appreciated by the community and government officials. There is a sense of trust and caring.

The Team were impressed by the sensitivity with which SC/US has moved into this politically active area and steadfastly maintained their apolitical stance, and also by the sensitivity with which the Project is working on the issue of women trafficking. The planning and activities of the project are appropriate, and the quality is good. The project work should continue as planned with additional emphasis on promotional activities, family planning and sustainability.

The staff are overstretched given the enormity of the task, the difficult terrain and the short time frame. They should consider reducing the number of activities or more staff, preferably local, should be recruited to assist with health promotion activities and support. The MTE Team presented its findings to the Director General of the MOH, other senior MOH and SC/US staff . The Team Leader presented and discussed the findings with the Save the Children/US Field Office and senior Project staff.

The author of this Report is Carrie Osborne, MTE Team Leader.

I. Introduction to the Mid-Term Evaluation

The Mid Term Evaluation of the Save the Children US "Empowering Families to Promote Child Survival in Nuwakot" project took place from Tuesday 12 April to Monday 25 April 1994 (see Appendix 3 for the Itinerary of the MTE Team).

The Mid Term Evaluation Team consisted of:

* Dr Laxmi Raj Pathak, Central Region Medical Director, Nepal
* Sharada Pandey, Chief, Child Health Section, MOH, Nepal
* Naramaya Limbu, Deputy Public Health Coordinator, SC/US, Nepal
* Kim Wylie, Desk Officer, Asia Region, SC/US Head Office, USA
* Carrie Osborne, Primary Health Care Consultant, UK (Team Leader)

Brief biodatas are given in Appendix 1.

See Appendix 2 for the Objectives of the MTE and the Terms of Reference of the MTE Team Leader and the team members.

The evaluation took place in Kathmandu and in Nuwakot District (See Appendix 3 for the MTE itinerary and Appendix 4 for a list of people interviewed and activities observed). In Kathmandu the work comprised both meetings and a literature review. The review covered the project proposal, the DIP, quarterly and annual reports, baseline and MTE cluster survey reports, qualitative research reports, IEC materials and training curricula. (See Appendix 5 for a list of documents reviewed). The team members held meetings and interviews with staff from USAID, MOH and SC/US.

In Nuwakot, the Team visited the District Headquarters at Trisuli Bazaar and all three project Ilakas. The Team divided into two groups to enable a wider area and range of activities to be observed. The Project area being inaccessible by car, the team travelled on foot.

The MTE Team held focused interviews with 40 community members, 6 political leaders, 16 project and MOH field staff, 4 district officials, 9 Kathmandu-based SC/US managers. The Team observed 10 field activities such as non-formal education classes, child-to-child classes, out-of-school classes and a mobile clinic.

The strengths and problems of this MTE and suggestions for future MTEs, as reviewed by the MTE members, are summarised in Appendix 6.

As Guidelines for the MTE for CSVIII projects had not been received from A.I.D. this MTE Team used Guidelines issued in July 1993 for CSVII projects, apparently little changed from CSVI projects.

The Team witnessed a number of educational activities for children in which they sang of the importance of **"an open eye, an open ear and an open mind"** - surely a good example for an evaluation team!

The Team felt that they had a very tight schedule given the complexity of the project and the difficult terrain. The Team Leader underestimated the time required for obtaining the answers to all the MTE Guidelines questions. It would have helped had the project staff had copies of the Guidelines in advance.

The format of the report is as follows: after a description of the project there follows an analysis and discussion of the project according to the A.I.D. MTE Guidelines. Conclusions and recommendations are given in the text and the main ones are summarised in Chapter 8. Photographs are attached in Appendix 8.

*II. Description **of** the Project*

"Empowering Families to Promote Child Survival in Nuwakot" has as its goal to reduce infant, child and maternal mortality and morbidity by empowering families to address their own health, education and development needs, and by creating an increased demand for improved government health services.

The Child Survival VIII project is being implemented in Nuwakot District by Save the Children US (SC/US) in close coordination with the Ministry of Health (MOH) and the District Health Office (DHO) in Nuwakot.

The CSVIII project is in receipt of a 3 year grant from USAID totalling $412,250 with USAID funding matched by $137,417 from SC/US private funds.

The objectives relate to a wide range of child survival issues: immunisation, diarrhea, HIV/AIDS, **acute** respiratory infections, nutrition and vitamin A, female literacy, maternal health, family planning, early childhood development, and sustainability.

The project is being undertaken in Ilakas 1, 12 and 13 of Nuwakot District. These Ilakas are primarily inhabited by the Tamang, the largest Mongolian tribal community in Nepal, but one of the least developed in the country. Most depend on subsistence farming and nominal livestock rearing. Many of the farmers are tenant farmers, some are bonded labourers, much of the land is owned by absentee landlords.

There is a limited health infrastructure; health posts are poorly staffed and supplied. Health status is low, with diarrhea, measles, and Vitamin A deficiency being key problems for children. There is little health care available for pregnant mothers. Few childbirths are attended by trained health workers.

There is low status and a lack of opportunities for women. Many adolescent girls are recruited from the project area for trafficking to Indian cities as prostitutes. These women and the general population are at increased risk of STDs, including HIV infection.

Activities include non-formal education through literacy classes (basic and advanced) for both men and women; Out-of-School classes for school age children who do not/cannot attend school; Child-to-child classes. Health promotion forms the basis of much of the material for the NFE. The project also assists the MOH with bimonthly mobile clinics timed to coincide with the EPI vaccinations. The mobile clinics provide treatment for under-5 children and prenatal and postnatal checks for women. The project is helping to form a number of community groups such as MCH Mobile Clinic Management Committees and Women's Savings Groups.

1. **Accomplishments**

How many months the project been operating?

The project has been operating for 19 months, since October 1992.

What are the measurable inputs, outputs and outcomes?

There have been a creditable number of training programs organised since the start of the project, covering the wide range of project activities, as indicated in the table overleaf.

In addition to the training carried out as outlined many other activities have been undertaken and outputs and outcomes achieved, some of which are summarised below:

EPI

EPI camps have been held on a regular basis with the MOH team. Community volunteers and MCH Management Committee members have encouraged the attendance of mothers and children. The EPI is held as part of the MCH Mobile Clinics, 147 Clinics have been held. However the day the MTE Team visited the VHW did not come with the vaccines. This has been a frequent problem but has improved since the project started.

A protocol for monitoring the cold chain has been developed based on a protocol of the Ministry of Health, and is being successfully used in the project area. This is attached to the Year 1 Annual Report.

A total of 2723 children under 5 have attended the MCH Mobile clinics.

According to the MT Survey 21.6% of children between 12-23 months have complete immunisation coverage as compared to 2% at baseline.

Diarrhea

The project promotes the use of Jeevan Jal (ORS) to prevent dehydration and the importance of maintaining fluid intake and feeding. (Cereal-based ORT has not been promoted. In this hilly area with limited firewood, people cook rice by the absorption method with no excess fluid. The MOH have tried in 5 similar districts with no success.)

90 'ORT Comers' have been set up to regularly demonstrate the use of ORT to NFE participants (40 were planned). This has involved providing demonstration equipment and training the facilitators.

In the MT Survey 20.3 % of mothers with children under 2 years reported giving ORS to their children during diarrhea, compared to 9% at baseline.

Focus group discussions have been held with different ethnic groups on Jeevan Jal.

Type of Training	Participants	No.
EPI	NFE Facilitators	162
	Parents groups	16
Diarrhea and ORT	CHVs	104
	NFE Facilitators	134
	Traditional Healers	40
	NFE Supervisors	20
ORT Comers, EPI, ARI, FP	NFE Facilitators	162
Jeevan Jal Sales distribution	Management Committees	2 gps
	Savings Groups	2 gps
STD/AIDS	School teachers	97
	CHVs	103
	Traditional Healers	82
	TBAs	29
	Peer Counsellors	77
	High School students	12
	High School teachers	4
	Village Health Workers	9
	Health Post in-charges	2
	AIDS Educators	3
AR1	CHVs	103
	Traditional Healers	59
Vitamin A	Health Post in-charges	2
	CHVs	36
	OSC NFE Facilitators	134
Kitchen Gardens	Women's groups	4 gps
Potato Cultivation	Women from Group	28
NFE Facilitator (Basic)	NFE facilitators	104(Yr1)
		62(Yr2)
NFE Facilitator (Advanced)	"	60
NFE Facilitator (OSC)	"	52
NFE Supervisors	"	14
Learner Generated Materials	Women's groups	24
Pregnancy and Delivery Care	TBAs (basic)	40
	TBAs (refresher)	26
MCH Clinic Management	Management Committees	20 gps
	VHWs	7
	CHVs	104
	Health Post in-charges	3
Early Childhood Development	School teachers	66
	NFE Supervisors	3
	ECD Educators	3
Home Based Child Care Centres	Mothers groups	3 gps
Parenting Education	Parent groups	22 gps
Leadership and Management	Women's groups	12 gps
30 Cluster Survey	Enumerators	53
Recording and Reporting	CHVs	66
	Health Post Staff	10
	TBAs	23

STD/AIDS

The project has collaborated with the National AIDS Prevention and Control Programme and WHO for AIDS education activities in the area.

The issue of women trafficking is documented in the "Qualitative Study on knowledge, attitude and practice regarding STDs and AIDs" using focus group discussions and in-depth interviews. The size of the problem is unclear. The MTE Team heard varying reports that 25-75% of girls go to Bombay as prostitutes. Further documentation following tactful research to ascertain the size of the problem would be useful. It is important to substantiate the rumours that abound on this issue. The Team heard many stories about trafficking but it is not clear whether it is the major problem in the area. Staff also feel that it is a dangerous issue to be documenting. The Team feel that project staff are treading carefully and that the confidence building in the community will take time but will be successful in the end. The project staff have taken great care not to draw attention to this issue, which may involve local influential people.

77 Peer Counsellors have been trained. These are women who have been prostitutes in India. The training was clearly difficult. The participants were interested in some aspects of health education but were reluctant to discuss AIDS. It will be interesting to follow up these women to see if they have been working as intended.

ARI

In addition to training of community people and health staff, ARI is being diagnosed and treated at the MCH Mobile Clinics.

The MTE survey results showed that 39% of mothers of children under 2 years recognise the danger signs of ARI and know where to refer, compared to 5 % at baseline. 53.2% of mothers interviewed sought treatment for their children with ARI compared with 55.4% at baseline.

Vitamin A and Nutrition

Vitamin A distribution at baseline was found to be 0%. The MOH do not consider Nuwakot to be a Vitamin A deficiency endemic area hence do not provide Vitamin A capsules on a regular basis for prevention. The project has been given capsules by the MOH for Nuwakot. In the DIP the project decided to distribute Vitamin A capsules by special camps twice a year. Camps were undertaken in Ilaka 12 in May 1993. The lessons learned (and reported in the Quarterly Report April-June 1993) suggested that it would be more appropriate to distribute and educate about Vitamin A during the regular MCH Mobile Clinics. It also showed that CHVs required training in Vitamin A. However a further camp was held in November 1993. In December 1993 the campaign successfully distributed Vitamin A capsules through the CHVs in their own wards.

The project is promoting the development of kitchen gardens, the necessity of eating Vitamin A-rich foods and educating about the consequences of Vitamin A deficiency. So far 4 Women's Groups have had training on kitchen gardening. The project will be adapting the MOH and VITAB/National Vitamin A Programme flip chart and posters on Vitamin A.

The MT Survey showed 28.4% of children have received Vitamin A supplementation compared to 0% at baseline.

Female Literacy

The project has organised the setting up of NFE centres throughout the project area. In Year 1 104 NFE Basic classes were started of which 90 centres functioned through the year. 1322 adults passed the literacy test of which 886 were women.

In this second year 75 NFE Basic classes were started of which 60 centres are functioning; 73 Advanced classes were planned of which 65 are still functioning; 60 Out of School Classes were planned of which 46 are functioning, making a total of 171 classes running six days per week six months of the year, an astonishing achievement. This year 822 women and 455 men are attending basic classes, 879 women and 373 men are attending advanced classes, and 675 female children and 583 male children are attending Out of School Classes. The results from these classes are not available as the terms are not yet complete. The participants' mid-term evaluations have recently been undertaken.

All the child survival messages are included in the material developed by the Ministry of Education and used for the basic non formal education classes. Additional NFE materials have been developed as extra reading materials and for use in the advanced classes. These all contain child survival messages. All the materials are excellent. The facilitators and school teachers are taught participatory teaching techniques, how to involve participants in an active way and to encourage practice at home of what it taught in the classes.

Maternal Health

147 MCH Clinics have been carried out to date. 709 antenatall postnatal checks were undertaken.

TT camps have been undertaken in 13 locations in Ilakas 1 and 12. 554 women received one dose of TT. As these camps are unlikely to be sustainable by the MOH they have been discontinued with a plan to improve coverage through the MCH Mobile Clinics (Quarterly report July-Sept 1993).

The MT survey showed 46.6% of mothers have received 2 or more doses of TT through either EPI MCH Mobile Clinics or TT mass camps. 19% of the mothers interviewed knew 2 of the 3 clean birthing practices, only 2 % knew 3 clean practices.

Family Planning

Breast feeding is common and encouraged. It is the main form of contraception in the area.

Family spacing messages are included in the NFE materials and have been included in school health education classes.

Sterilisation Camps were held in four places in each of the 3 Ilakas over 7 days by the MOH with assistance from the project. 83 men had vasectomies. Lessons learned include: CHVs should be given orientation for them to encourage clients; a formal agreement should be made with the Family Health Division; camps should be held at Health Posts to provide space and supplies; it is important to share resources with the DHO.

Focus group discussions have been held with different ethnic groups (Pradhan, 1994).

At Mid-term 12.2% of couples who do not want more children used any method of family planning, compared to 8 % at baseline.

Condoms are usually available from the MOH clinics but other contraceptives are in poor supply.

Early Childhood Education

A Workshop was held in January 1993 to develop the policies for Parenting Education (PE), Home-Based Child Care Centres (HBCCC) and Child-to-Child education (C-C). Definitions, objectives for the programs, policies, strategies and indicators are given in the Jan-March 1993 Quarterly Report.

All 37 Mothers Groups set up in the past by the MOH/CHVs but found to be no longer functioning have been revitalised.

22 male and female Parenting Groups have been formed.

10 Child to Child groups have been formed.

3 Home Based Child Care Centres have been formed, 1 in each Ilaka on a trial basis.

Sustainability

13 Women's Savings Groups have been formed from those passing the Advanced NFE classes. It has been hard to form these groups as many married women do not have the tune to participate in NFE classes, and some are earning more from other sources such as prostitution.

12 of those Women's Groups have received training in leadership and management.

28 MCH Mobile Clinic Management Committees have been formed. 20 of these have received management training.

10,000 tree saplings have been planted by NFE participants and Savings Groups members.

To date, how many infants, children under five, and mothers have been reached by CS interventions under this project? What proportion is this of the total potential beneficiary population of infants, children under five, and women of child-bearing age?

The total beneficiary population of the project area is 38,098. Of these, 7,620 are women aged 15-45 and 6,096 are children under 5.

It is difficult to ascertain how many infants, children and mothers have been reached by this project as many of the activities suppose a 'trickle down' effect from the health education with parents, NFE participants and the Child to Child activities. Some will have been reached directly, many will have been involved in some way in the mass educational activities.

2. Relevance to Child Sur[illegible] Problems

What are the main causes of child mortality and morbidity in the project service area?

There is no data in the Baseline Survey Report from MOH health post records giving an indication of the causes of mortality or morbidity. The Project Proposal suggests that the main causes of child morbidity in the project area are diarrhea, respiratory infections, fever, skin diseases. The commonest causes of death in infants and children under 5 are ARI, measles and malnutrition.

Maternal education is considered a contributing factor to child morbidity and mortality: female literacy rate in the project area is a very low 3 % .

What are the child survival interventions and health promotion activities initiated by the project?

EPI, diarrhea1 disease prevention and management, STD/AIDS prevention, ARI, Vitamin A deficiency prevention and treatment, nutrition education, non-formal education (literacy, Out-of-School classes and Child-to Child), maternal health, family planning, early childhood development (Parenting Groups, Home-Based Child Care Centres), sustainability (Women's Savings Groups for production credit, MCH Mobile Clinic Management Committees).

Strengthening of service delivery systems through training of DHO and health post staff, local health volunteers and community leaders.

Support to mobile health clinics to provide regular childhood and maternal immun.isation services, treatment of simple conditions in the under fives, care of antenatal and postnatal women. Camps for TT, STD, vasectomies, Vitamin A capsule distribution.

Is the mix of project interventions appropriate to address the key problems, given the human, financial and material resources to the project and the community?

The mix of interventions is appropriate for the needs of the project area. However the vast array of activities has meant that staff are overstretched.

The MOH is failing at present to provide a regular supply of vaccines or adequate referral services.

More SC/US or local staff are required to undertake health promotion activities and to provide support. (See Section 5.4 Human Resources)

Is the focus or prioritisation of interventions appropriate?

The focus is appropriate but given the difficulty of recruiting staff and the low level of health awareness in the community it may be better to prioritise the interventions and so reduce the number of activities attempted.

3. Effectiveness

What is the relationship between accomplishments for this period and objectives for this period? Has there been sufficient progress in meeting stated objectives and yearly targets? Are targeted high-risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

The Project Team have achieved a high level of accomplishments. Progress is remarkable given the circumstances and the demands. Planned activities have virtually all been carried out. Most quarterly targets have been achieved. A plan for yearly targets was not included in the Year 1 Annual report.

There has been less emphasis on family planning than originally planned. No training has yet been given to CHVs, TBAs, Traditional Healers or Village Health Workers though it is included in the training of the NFE Advanced facilitators. The supply of contraceptives has yet to be strengthened.

Accomplishments are not uniform across the three Ilakas. The more remote areas and Tamang communities have been difficult to work in to gain the confidence of the community.

A strength of the project is that Out-of-School classes and NFE classes are composed of mixed

sex, caste and ethnic groups so encouraging an atmosphere of reducing segregation.

Certain groups are being reached, such as mothers and children. However the project staff expect that there will be a trickle-down effect.

The Tamang community are much more reserved and conservative than was estimated by the project. It has taken time for SC/US staff and activities to be accepted.

Referral to health posts is hampered by the irregular working of health post staff. The MOH has not been reliable in providing manpower and supplies for EPI, family planning and Vitamin A.

The project is working in a remote and relatively inaccessible area, seldom reached by government services. A major constraint to project success is the topography of the area. Every project activity requires the staff to walk, sometimes for considerable distances, on rough terrain, in sun and rain. Some visits in the Ilaka may take 5 hours to walk in each direction. This takes its toll on the capacity of the project staff. New staff, sometimes from urban areas, have to get used to this strain.

The Home Based Child Care Centres, designed to assist high risk mothers and children, have been difficult to form. Many mothers simply do not have the time to consider the physical and emotional growth of their children. Some mothers seasonally migrate for work.
There needs to be a more intensive program to give parenting education to the whole community.

The Women's Savings Groups are hard to form in the more remote areas. It may be useful to enable women from these areas to visit and discuss with more active groups.

The Savings Groups in Ilaka 13 felt that they were unable to raise sufficient money quickly enough. For savings from local work to be a viable alternative to working as a prostitute the income must be higher.

4. Relevance

What are the main community barriers to meeting the basic needs of children?

Poverty, lack of mothers' time, low maternal education, illiteracy, high mountainous terrain, conservative ethnic group (Tamangs), poor sanitation, lack of availability of Vitamin A rich food, poor referral services.

What has the PVO project done to date to increase the ability of families to participate and benefit from child survival activities and services?

Literacy classes, parenting classes, Mothers Groups. Provision of MCH Mobile Clinics closer to people's homes. Training of CHVs, TBAs and Traditional Healers who can provide local health advice.

Is the PVO fostering an environment which increases community self-reliance. enables women to better address the health and nutrition needs of their families?

Yes, through its broad activities and careful work with community people. As with the CSVII project in Siraha the MTE Team feel that the combination of literacy training, especially for women, and an integrated community development program with a strong health component, is proving a successful development strategy.

Use of health education materials in the literacy curriculum, particularly for women, is an effective way to reach a large target audience with health education messages.

5 . Design and Implementation

Are there any particular aspects of project design or implementation which may be having a positive or negative effect on meeting project objectives? Taking the following;

5.1 Design

Has the project limited its project area or size of impact area population?

The project has been initiated in the 14 Village Development Committees of Ilakas 1, 12 and 13 of Nuwakot District, the more remote areas of the District least served by government services.

Has there been a car-n of project service activities?

The project has undertaken a wide range of activities in the short time since it commenced. Clearly the project staff feel under pressure to carry out activities planned in the DIP. The staff have been careful to plan activities after having trained the appropriate community volunteers and health staff.

There has been a rapid expansion of NFE. There have been some instances of classes failing: some participants drop out as they are unable to commit the time. In some areas NFE facilitators are in short supply, some work in more than one VDC. Sometimes participants do not support the facilitator because of their political affiliation.

NFE classes are taking both male and female participants. This is wise as the area has a low male literacy rate also. The project staff report that husbands are more likely to let their wives attend when they have attended first.

Has the PVO set measurable objectives of outputs and outcomes?

The PVO has set measurable objectives but there is a problem of measuring all these objectives using the A.I.D. baseline and mid-term survey formats. (See 5.2)

Has the project management been willing to make changes when appropriate, and can the PVO justify or give reasonable explanation of the directions and strategies the project has undertaken?

The project management has been willing to make changes. The PVO has given reasonable explanation of changes in its quarterly and annual reports. For example, it has proved difficult to set up Home-based Child Care Centres (HBCCC) so it is unlikely that the appropriate target for some of the MCH objectives will be reached. The project staff have recognised that a different approach is required and are considering Family Based Child Care Centres.

5.2 Management and

Is the project collecting simple and useful data?

Yes, the project generally collects appropriate data for the planning of activities and the assessment of accomplishments.

A baseline and mid term cluster survey has been carried out. Routine data is collected on service sheets at MCH mobile clinics covering antenatal and postnatal women and under five children. EPI coverage by antigen is collected from the VHW registers, where these are available. A Family Planning form for acceptors is completed and returned to the DHO. Records are kept of NFE classes, tests are given to NFE class participants to assess their literacy capability.

The new MOH Health Information System using standardised forms and procedures will be given a trial in the area.

Records are kept of all inputs and outputs.

The project keeps records of meetings held with District government officials, and of quarterly project staff meetings.

Do the indicators need refinement?

The current indicators for the CSVIII interventions have been developed as given in Appendix F, Year 1 Annual Report. The objectives have been changed with explanation from the proposal and from the DIP as given on p. 8-10 of the Year 1 Annual Report. The Project Team needs to review the objectives and the indicators and ensure that the objectives can be measured by the indicators. The following table summarises the current objectives, the current indicators and the data source, suggests some refinements and raises some queries that need to be addressed by the Project Team and should be reported in the end of Year 2 Annual Report.

Current Objectives	Current Indicators	Data Source and period	Comments/queries
40% of children 12-23 months will be fully immunised against BCG, DPT, polio and measles	% of children under 1 year who receive vaccination by each antigen dose % of children 12-23 months who have completed dose of immunisation by year 1	HP/VHW/ORC record, quarterly Survey data, baseline, midterm and final	These are confusing indicators incompatible with the objective. The objective can be measured from the surveys. Indicator: % of children 12-23 months fully immunised for each antigen. Does this need to be % of all not just those with EPI cards?
25% of women between 15 and 45 years will be immunised against tetanus by MOH norms	% of women 15-45 who have received at least two doses of TT	HPIVHWIORC record of TT by age, quarterly	The data needs to come from **all** women aged 15-45 not just those with children under 2 years or those with TT cards. The data source is the MTE and final surveys.
At least one member in 50% of families with under 5 children will prepare ORS correctly	% of mothers of children with diarrhea who received ORS packets % of above 10 population who attended diarrhea and ORS education session % of families with children under 2 and 5 years who have at least one family member knowing correct preparation and use of JJ	HP/VHW/CHV/SA/ORC record of JJ distribution, quarterly HP/VHW/CHV/SA/ORC/NFE/WSG record of diarrhea education sessions participant number, quarterly Survey data with information by child's age, annual	How will you assess 'correctly'? Current indicators will not measure objective. Need to use survey data as source. Perhaps change objective to 50% of mother (or caretakers) with under 5 children will prepare ORS correctly. Will need to have checklist for survey.

25% of children with diarrhea in the last two weeks will be treated with ORT (Jeevan Jai)	% of children under 2 and under 5 years with diarrhea in past 2 weeks who were treated with ORS	Survey data with information by child's age, annual	Why aged 5 also? Annual, or baseline, mid term and final? If the mother does not know how will you ask all other family members? Perhaps change objective to 25% of children under 2 years (or 5) with diarrhea in the last 2 weeks will be treated with ORT (JJ) - you have baseline and MTE survey data for this.

50% of men and women will be knowledgeable about three main modes of HIV/AIDS transmission and three protective behaviours	% of men and women aged over 10 who know at least three main modes of HIV/AIDS transmission and three protective behaviours	Survey, annual	It may be better to use men and women between 15-45?
	% of population aged over 10 years reached by AIDS/STD education messages	HP/VHW/CHV/NFE record, quarterly	How will you be sure you are not counting people more than once using this data source?
	% of STD infected men and women treated in the special camp	STD camp record	How will you find out the denominator? How is this helpful as an indicator?

25% of mothers will know the danger signs for ARI and where to seek treatment	% of mothers with child under 2 and 5 years who know signs for detection of pneumonia which requires medical attention (cough and rapid breathing) % of mothers who know where to go for treatment for severe ARI % of mothers who sought medical treatment for their children with severe ARI	Survey data by age, annual Survey data, annual HPIORCIVHW record of treatment, quarterly	Should this be two separate objectives? ('know the signs' and 'where to treat'. This has been obtained from MTE survey. Where will you get the denominator?
40% of children between 6 and 60 months will receive Vitamin A supplementation every 6 months	% of children under 5 who received Vit A supplementation	VHW/ORC record, quarterly	indicator should be for 6-60 months Consider adding an objective for K&P of Vit A rich foods
60% of mothers will introduce supplementary weaning foods to their children between the age of 4 and 6 months	% of infants between 6 to 24 months who are being given solid or semi solid foods additional to breast milk % of mothers who have received nutrition education	Survey, annual VHW/CHV/ORC record. quarterly	
60% of mothers will mix additional fat into their children's food	as above		These nutrition objectives need careful indicators. Will you measure all mothers or those with children under 2 or 5. Consider changing the objectives to mothers with children under 2 /5.
60% of mothers will know that they should NOT actively reduce their children's food intake during illness and that they should INCREASE their children's food intake during convalescence	as above		

50% of mothers will NOT actively reduce their children's food intake during illness and will increase their children's food intake during convalescence	as above		How are you going to measure this change of practice objective? Hard to observe. Are you going to develop objectives on K&P of nutrition during Pregnancy and lactation?
Female literacy rate increased to 30% of 15-45 year population	No indicators or source of data given		Presumably data taken from NFE records?
40% of mothers will know the three clean birth principles	% of women 1545 who are reached by the message of 3 cleans for safe delivery % of women who know 3 cleans for safe delivery	HPIVHWITBAINFEI CHV record, quarterly Survey, annual	 Women 15-45
20% of mothers who will have delivered in the last year will have attended at least one prenatal care session	% of women who have an prenatal checkup % of deliveries attended by trained TBA or health worker % of post natal mothers followed up by trained TBA or health worker	HP/ORC record HP/TBA record HPIVHWITBA record	Will this objective be measured by the surveys? These two indicators are redundant as the relevant objective was rightly dropped in the DIP.
15 % of eligible couples will use any method of contraception	% of currently married 15-45 women using permanent method of family planning % of currently married 1545 women using a spacing method Couple years of protection (CUP) from permanent and temporary methods of family planning	HP/DPHO record, quarterly HP/VHW/CHV/ORC/ record, quarterly HP/VHW/CHV/ORC record, quarterly	Also measure from survey
20% of families will be trained in health and stimulating child care practices			How will this be measured?

30% of community groups formed will be operating independently			How will this be measured? Define 'independently'

It may be helpful for the Team, when they plan their quarterly/annual inputs and outputs, to state the specific indicators and data source so that they can see achievements or problems more easily. Project staff may find that a tabular planning format rigorously used for each intervention, such as is given below, would be helpful.

Objectives	Planned Inputs	Outputs	Outcomes

What is the balance between qualitative and quantitative methods of data collection?

The project is striking a good balance between quantitative data collection from surveys and records and qualitative research to attempt to find out particular issues to improve project activities and community involvement. Two qualitative research studies have been carried out, one on STD/AIDS and the other on family planning, oral rehydration therapy and acute respiratory infections. The Project are planning to carry out a focused ethnographic survey of ARI. It will be difficult to achieve good quality data on the Bombay sex trade.

Is the project using surveys for monitoring and evaluation?

Yes, the project has undertaken baseline and mid-term cluster surveys which it is using for monitoring and evaluation. The baseline survey was designed using a standardised format required by USAID for its Child Survival Projects, with refinement after pre-testing.

Difficulties arise in the project monitoring as Objectives have been written in a way that does not fit into the USAID design for the surveys. The Mid Term Cluster survey designed by USAID does not give the flexibility to collect data to assess all the objectives of this Project. In order to measure the project's impact compared to its objectives the final survey will need to obtain data from men and women with older children as well as from mothers with children under the age of two years.(See the section on Indicators) However the project staff should examine this requirement and look at the objectives as a much wider survey may not be cost-effective.

Lessons learned during the baseline survey suggests that the tentative questionnaire be prepared well ahead. Discussions are already going on regarding the final evaluation survey to ensure feedback from all concerned. Other lessons are: to print extra questionnaires for training and contingency; to hire only local interviewers so that all are on the same benefits; to limit the questions to those concerned with the target group; not to ask questions about economic status, literacy and demography from the mothers of children under two years old, as it is not feasible to generalise the information for the whole population.

How were baseline data used for project development?

Results from the surveys have been shared with many concerned individuals and groups and discussions have helped to steer the design of the project development.

Project staff felt that the baseline survey was indispensable in developing the DIP. Following presentation and discussion of the results with local leaders and District personnel, the entire Nuwakot project staff reviewed the findings and developed the DIP during a three day workshop. Objectives set during the proposal stage were refined to reflect the reality of the community situation and more achievable targets set.

Information from the baseline survey has been used in many ways such as:

- development of 'Jeevan Jal/ORT Corners' at the Mobile Clinics to provide education on dehydration and demonstration of the use of ORT,

- promotion and provision of antenatal care at mobile clinics

- information obtained during the baseline survey forms the basis for the design for the STD/AIDS flip chart, and includes information on tattooing,

- data from the baseline survey, which showed that no children ever received Vitamin A supplementation, was used to persuade the MOH to provide Vitamin A capsules for the project area,

- inclusion of a reminder to mothers attending EPI that cards should not be lost, as many mothers were unable to answer the questions during the survey because they had lost their cards.

It is the basis for many other health promotion activities.

Are data being used for decision making? (give examples)

Yes, the project is using its data well to track input and outputs and to assess accomplishments against objectives. (see 1. Accomplishments)

A summary of the findings of the baseline survey was presented to the Ministry of Health, District Public Health officials, VDC members, health post staff, school teachers and other local NGO staff. Senior project staff shared the findings with Kathmandu-based MOH and district officials. Feedback from those concerned assisted in the development of the DIP.

The Project is completing thorough Quarterly reports for submission to USAID. It would be

helpful if the list of objectives/ achievements for the quarter followed the same format as that for the planned activities for the previous quarter, with additions at the end and an explanation of changes made. It would also be clearer for the MTE Team and the staff if the planned activities were written in such a way as to relate them to the Project objectives.

The quarterly Reports are very useful for project staff to analyse their accomplishments and plan future activities. However the Team recognise the time that is taken for this and suggest that quarterly reports continue to be produced, but that they are internal documents. An Annual Report to USAID should be sufficient. The quarterly reviews are clearly helping to refine activities: the proposal to change the focus of HBCCC to family-based centres is a good example.

Is the project's routine health information system fully functional?

As planned in the DIP the project does not have a 100% enrolment HIS. Records are maintained of inputs and outputs. Outcomes are and will be measured using data collected from periodic surveys.

The MOH system is not functioning well. One of the roles of the MOH Village Health Worker (VHW) is to maintain a register of all households in the Village Development Committee area. In the project area the VHWs do not maintain these registers well. Only where the VHW is active is this being updated in any regular way. Project staff are trying to encourage the work of the VHWs, but it is proving hard to motivate them to come for training or work.

The project finds it hard to identify high risk families as clear data is not available. To some extent staff are identifying groups by observation, hearsay and discussions with community leaders.

Do the local staff have the skills to maintain the information system?

The SC/US staff have the expertise and experience to maintain the limited information system and to undertake qualitative data collection. Outside consultants are usually used to provide some assistance in planning and analysing quantitative surveys.

The baseline survey was conducted by a team of 12 project staff as supervisors, 33 interviewers from the local area and two from Kathmandu. The majority of interviewers were female because of the nature of the survey. The interviewers and supervisors attended a training facilitated by the Project Coordinator, the supervisors and coordinators and by senior SC/US program staff.

The MTE survey was carried out by project staff with 13 local supervisors and 25 local interviewers. Technical Assistance for training was received from the PVO CSSP Survey trainer, Cynthia Carter.

Difficulties often arise in the project area because there are three calendars in use. The local population of Tamangs, Sherpas and Gurungs use the Tibetan calendar. The project staff and government use the Nepali calendar. For reporting to USAID the English calendar is used. This can make for confusion in data collection and reporting. The project staff are aware of the difficulties and double check dates.

Have the results of the information collected been shared with data collectors, project staff, c o w s , and community members?

The Health Post in Charges were involved closely with the baseline surveys. A summary of the findings of the baseline survey were presented to the MOH District Public Health officers, VDCs' members, health posts' staff, school teachers, and other concerned NGOs' staff members. Nuwakot project staff shared findings with local VDC committee members at their monthly meetings. The findings were also shared with Kathmandu-based MOH staff, District government officials and with other interested parties.

Interviewers for the Baseline and Mid-term cluster surveys were hired locally which proved successful in involving local people and gaining their interest in the project. Local enumerators hand tabulated the results.

VDC Chairmen and School teachers were invited to Samundratar for a meeting to discuss the results. Many VDCs could not attend. The MTE Team recommend that more emphasis be placed on information-sharing, perhaps by having smaller meetings in Ilakas or wards.

Community Leaders are invited to quarterly meetings where results and problems are discussed.

Is the PVO, headquarters and/or field, institutionalising lessons learned by documenting, incorporating and sharing?

The project staff are careful to write up a report of project activities, trainings etc. These usually include a section on lessons learned. These are attached to the Quarterly Reports.

The results of the Baseline Survey were presented by the Project Coordinator at the International AIDS conference in Berlin.

CSVIII Project Annual Reports are shared with other SC/US projects, with the MOH and the MOE, with the SC/US Asia Regional office and the Health Unit at SC/US Head Office. The Health Unit produce an 'Update' about projects which is sent to other country programs.

Quarterly meetings are held in Nepal of International NGOs. Information about the project and lessons learned are shared at these meetings.

The Public Health Coordinator, Chanda Rai, is on national 'Task Forces' for Vitamin A, Safe Motherhood and AIDS. She has given presentations about the project at meetings.

5.3 Community Education and Social Promotion

What is the balance between health promotion/social mobilization and service provision in this project? Is the balance appropriate?

There are more activities being carried out by the project on health promotion/social mobilisation than on service provision. The NFE classes are providing educational services for those underserved or unable to attend formal schooling. The mobile clinics are primarily for EPI but SC/US do provide a limited service for mothers and under-five year children. However as the clinics are only held bimonthly this service is really only designed to encourage people to seek out health care and to convince the community of its worth.

The problem of providing more services is that referral services through the health posts are inadequate and are unlikely to be sustainable by the government or the community.

The main emphasis on health promotion relies on the adequate functioning of the health posts in the project area. Although it is clear that some Village Health Workers are becoming more encouraged to work, the health posts are poor. The MTE Team feel that the project should discuss further with the MOH as to what is required at the health posts to encourage the health staff to work at them. The Team consider that there could be more emphasis on strengthening the health posts with community support and assistance from the project.

Is education linked to available services?

Yes. Health education activities are carried out at the mobile clinics and at health camps. They are an integral part of the NFE curricula. Very little health education seems to be undertaken at the MOH health posts.

Has the project carried out any community information, education, or communication activities?

The project should be commended for the effort it is making on community IEC activities. A wide variety of methods, materials and situations are being used, such as:

* Health promotion activities are carried out in schools, in Out-of School classes, Child-to-Child classes, MCH Mobile Clinics, NFE classes, VDC meetings, Parenting classes and many others.

* Opportunity is taken for health promotion at cultural shows, festivals, celebration days etc.

* Twelve signboards on AIDS/HIV transmission and protective behaviours have been prepared and erected in health posts, schools, offices and other public gathering places.

* Six local STDs/AIDS "Hotlines" are being used. These consist of a letter box and a bulletin board (see photo). Every week, anonymous letters which have been posted in the letter box are answered by project staff in a public letter on the bulletin board. This has proved to be very popular and there has been much interest in the answers. (There have also been examples of letters from the local youth that are too rude to answer!)

Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages?

Yes, the project staff are careful to use the data from the base-line survey, from the focus group research and from interviews with women's groups, community leaders and community volunteers.

Have the messages been tested and

Messages are being refined to suit the particular needs of the project.

How does the PVO ensure that messages to mothers are consistent?

The training of community volunteers and the use of flip charts and other materials helps to ensure that messages are consistent.

Does the project distribute any printed materials? Did the project pre-test printed materials?

There has been a long delay in developing new IEC materials with the late recruitment of an IEC Coordinator. Staff all feel that these materials were needed earlier and that it has been difficult to carry out IEC work appropriately. Skilled IEC developers are in short supply and high demand in Nepal. SC/US has had similar difficulty in recruiting skilled IEC material developers before in both the CSIII project in Gorkha and the CSVII project in Siraha. The new IEC Coordinator may prove excellent. However SC/US should also consider whether it may be necessary to hire a member of staff who can be apprenticed and trained.

The project has distributed some printed materials:

* Flip charts and leaflets on ORT and Child Spacing developed by the CSIII project in Gorkha

* Flip charts on Safe Motherhood and child care

An AIDs/HIV flip chart has been pretested and is in press.

The project has plans for more materials which will be developed, pretested and printed now that the IEC Coordinator has been recruited. Plans are well under way for the following materials:

* EPI -Flip-chart for training community volunteers
  -TT poster aimed at women between child-bearing age
  -Infant poster, to encourage women to take children for EPI
  -EPI sign on a tin sheet to be put in public places and at the mobile clinic site

* Diarrhea
  -Flip chart for training community volunteers
  -Booklets for neo-literates

* STD/AIDS
  -Booklet for NFE participants
  -Booklet for Senior school students
  -Flip chart for use in teaching

* ARI -Flip chart

* Vitamin A
  -Flip chart

* Maternal Health
  -Flip chart including safe motherhood and the '3 cleans'
  -Poster of '3 cleans'
  -Booklet for women

* Family Planning
  -Booklet on Depo Provera
  -Comic
  -Wall painting
  -Leaflet on vasectomy and minilaparotomy
  -Condom and Pill booklet for illiterate people

The Project may find it useful to link up with the Child-to-Child programme of the Institute of Child Health in London UK.

Do members of the community regardials as simple. useful. of value?

The MTE did not ask this.

The focus group research showed that some people, especially women, had some reservations about accepting explicitly illustrated IEC printed materials on AIDS and condoms. Research participants welcomed the idea of drama and video shows saying that such shows will always gather a large crowd. Research has shown that village people consider that it is important to use the local language in media and print materials, and to design special IEC programs for Tamangs and girl children.

Has the project been creative in its approach to community education, such as incorporating any non-traditiona1 or participatory education activities?

Yes, the project has used research to suggest important channels for IEC activities. e.g. public speeches, posters, dances, songs and drama.

Activities used:

* An exhibition on child survival, AIDS/HIV, literacy, and women's development was organised for the festival of Tij.

* Quiz Contests at secondary schools and with NFE participants on health and AIDS.

* Learners' generated materials workshop, and production of "Chetana" booklet.

* Celebration of World Environment Day in one Ilaka with speeches, rally, slogans and placards.

* Celebration of World AIDS day in the three Ilakas, involving: the introduction of the 'AIDS Hotline'; banners; a procession with placards organised by community groups and SC/US staff in which 900 people participated; speeches; songs sung by NFE facilitators; Condom Blowing Competition; distribution of booklets, posters and pamphlets; a drama show in Ilaka 1 helped by a NFE facilitator.

* Celebration of International Women's Day in each Ilaka.

* Celebration of National Education Day with marches; demonstrations; quiz contest; cultural program; speech competition; song competition among NFE participants and school students.

* The AIDS Hotline.

* Street Drama organised by the Chaap VDC in Ilaka 1, prepared by the NFE facilitators and supervisors. Street Drama on EPI prepared and shown in Ilaka 12. AIDS related

Street Drama prepared and held in Ilaka 13.

* Kitchen Garden demonstrations in Ilaka 1.

* Exhibition at a Secondary School for a local Jatra (fair), with distribution of leaflets, booklets, condoms and posters.

* Street drama on STD/AIDS, in coordination with ABC Nepal, a Nepali NGO.

Has the project assessed the level of learning thathas occurred with -methods. or is the evidence for effectiveness anecdotal?

This has not been assessed. The CSIII Project in Gorkha assessed the use of drama and found it to be very effective, with a high rate of recall. The project could consider researching the effectiveness of methods in Year 3.

5.4 Human Resources for Child Survival

How many persons are working in this child survival project?

There are 19 staff working 100% time on the project. There are another 11 staff whose salaries are part-paid by the USAID grant and/or SC/US matching funds. The MTE Team interviewed the majority of these staff. Additionally there are 5 locally employed NFE supervisors, 3 ECD Educators, 2 AIDS educators (plus 4 others paid from a WHO grant), one MCH Worker, a messenger and a storekeeper and three cooks paid from SC/US funds.

The MTE Team are impressed by the well qualified, trained, competent staff, working extremely hard in all sectors in this difficult project area. The Team are particularly pleased to see such excellent team spirit.

SC/US have employed good, strong female staff who will be excellent role models in the community.

Staff Working the CSVIII Project

Name	Designation	Grant %	Match %
Bharat Devkota	Program Director		25
Chanda Rai	Public Health Coordinator	25	25
Naramaya Lirnbu	Dy Public Health Coordinator	17	50
Ravindra Thapa	Project Coordinator	100	
Neena Gauchan	Field Coordinator	100	

Krishna Gurung	Field Coordinator	100	
Tulsi Gurung	Field Coordinator	100	
Nettra Bhatta	Staff Nurse	100	
Maya Kumari Gole	Staff Nurse	100	
Manoj Dhakal	CMA	100	
Motilal Biswhokarma	CMA	100	
Ranjana Kanal	ANM	100	
Udaya Manandhar	Education Program Officer		25
Bed Bahadur Lama	NFE Coordinator	100	
Rajendra Lama	NFE Coordinator	100	
Jay Shrestha	NFE Coordinator	100	
Shashi Rijal	Productivity Program Officer		25
Jamuna Lama	WD Coordinator	100	
Shova Lama	WD Coordinator	100	
Durga Regmi	WD Coordinator	100	
Sharmila Shrestha	WD Coordinator	100	
Sundar Mulepati	Research and Training Officer	25	
Min Dhoj Karki	IEC Coordinator	35	
Shankar Sunuwar	Finance Manager	25	
Binod Chapagain	Accountant	100	
Achut Poudyal	Liaison Officer	25	
Jeevan Tamang	Office Manager	25	
Puma Shrestha	Store Officer	25	
Urmila Kashyap	Program Support Supervisor	100	
Ram Prasad Shrestha	Driver	100	

Does the project have adequate numbers and mix of staff to meet the technical, managerial and operational needs of the project?

On first sight there would appear to be adequate numbers of staff; however when reflecting on the terrain and difficult circumstances in which the staff work, the low knowledge and health status at baseline, the breadth of activities of the project, and the lack of government staff at the health posts, the MTE Team recommend that further staff be employed for health promotion activities, and for office support in the Ilakas. The staff are all highly committed and working extremely well but seemed to be working at their limit and were under strain. They need more assistance to achieve the project objectives, particularly for health promotion activities in the community with people other than those attending NFE.

SC/US is going to hire an MCH Worker for each Ilaka and will train them by attachment using the MOH curriculum. Their role will be to assist with the MCH mobile clinics. One is already hired and is an ex-MOH MCH worker. As it is hard to find suitable women in the project area because of low education and their inability to travel far, then SC/US may recruit

one of the existing AIDS educators.

The project activities are heavily scheduled. If a staff member becomes sick or needs to be away then difficulties are caused and activities may need to be cancelled causing disaffection in the community.

The MTE Team are impressed with the commendable program of training and capacity building that has been undertaken to ensure that the project staff have the skills to undertake the project activities, as listed below:

Participants	Duration	Topic
Public Health Coordinator	5 days	Int. AIDS Conference, Delhi
Dy . PH Coordinator, Project Coordinator	10 days	AIDS Prevention Strategies
3 NFE Coordinators	10 days	TOT for NFE
3 Women's Dev Coordinators	7 days	TOT and Leadership training
All project staff	2 days	Planning Workshop
3 Staff Nurses, 1 ANM	9 days	Focus Group Discussion Research
All project staff	5 days	Cluster Sample Survey
4 Women Development Coordinators	5 days	ECD Observation, Lumjung
Project Coordinator	4 days	SC/US Regional Health workshop
10 NFE Supervisors	5 days	NFE Centre Supervision
3 NFE Coordinators 9 NFE Supervisors	10 days	NFE Observation tour, Gorkha
3 WDC	6 days	ECD TOT
Project Coordinator 3 Field Coordinators	2 days	Semi-Annual meeting
1 NFE Coordinator 3 Staff Nurse 2 CMAs	10 days	TOT Communication Skills

1 Field Coordinator 3 WDC 1 IEC Coordinator Dy PH Coordinator Health research and training Officer	5 days	TOT
1 Field Coordinator	3 days	Legal Rights
1 Field Coordinator	4 days	Gender Analysis
3 Staff Nurses 1 ANM, 2 CMAs	4 days	Quality Assurance Workshop
1WD Dy PH coordinator	6 days	CS Workshop, Bangladesh "People making a difference"
1 Staff Nurse 1 Education Coordinator	3 days	IEC Development Workshop
4 WDC 1 Field Coordinator 1 Project Coordinator	3 days	Productivity Sector meeting
3 Field Coordinators Project Coordinator 2 Staff Nurses, 1 CMA 2 WDC 1 Accountant	1 day	Institutional development Workshop
2 NFE Coordinators 1 WDC	2 days	ECD
Staff Nurse	7 days	AIDS TOT, Kathmandu
1 WDC	2 days	Parenting Education
4 WDCs	5 days	ECD TOT
1 Staff Nurse	6 days	Rural Communication
NFE Coordinator	3 days	Public Awareness

4 WDC 1 Field coordinator 3 Community AIDS Educators Accountant	7 days	Focus group research AIDS
Women's Dev Prog Officer	7 days	ECD Conference, Singapore

The main language spoken by the high risk groups in the project area is Tamang. The project is to be congratulated for encouraging the recruitment of some Tamang-speaking staff. However there are many staff who do not speak Tamang and use Nepali as the medium of health promotion, often without the use of an interpreter. The MTE Team feel strongly that some staff should speak Tamang.

The sectoral program staff based in Kathrnandu seem overburdened with administrative matters, and the secretarial staff very busy.

The MTE Team support the decision made by the project staff when developing the DIP that an expatriate Project Adviser was unnecessary. Senior project staff are suitably trained and experienced to manage the project. Some training needs to be given to improve their depth of understanding of budget management.

There is a high proportion of new staff working in the Ilakas, particularly Ilaka 1. The Team felt that it would be wise to ensure that each Ilaka has a mix of new staff and of 'old hands' who are experienced in the community-based development work carried out by SC/US in Gorkha. It is appreciated that the 'scaling up' of work by SC/US has meant that many new staff have had to be recruited. These staff seem well qualified but need to work alongside more experienced people to get a full understanding of the complexity of working in such a difficult area.

The project has found it hard to recruit experienced health workers because of the remoteness of the area; there are two vacancies at present.

Do these staff have local counterparts?

The staff of SC/US do not have individual direct local counterparts. The project staff work with the locally employed staff, with members of the community and MOH staff.

Initially it was hard to recruit local staff because the area is politically active and people were concerned that there would be a political viewpoint to being employed by SC/US. However, as the community have become more confident in the project and SC/US has shown itself to be scrupulously apolitical more local people have been interested to work and be involved with the project.

Are community volunteers taking part in this project? How many are in place? Are they multi-purpose workers or do they concentrate on a single intervention?

There are many community volunteers taking part in the project. Community Health Volunteers (CHVs), Traditional Birth Attendants (TBAs), Traditional Healers, Peer Counsellors, Non Formal Education Facilitators are actively involved and working hard. They all are multi-purpose workers in that they all work in various aspects of health promotion.

The community volunteers interviewed by the Team were aware of the project's activities, were all very happy to be working in the project area, appreciated the encouragement and help received by the project staff, and had learned many new subjects in their training and at the 3-monthly meetings. They were aware of the problems of their community particularly related to children and pregnant women. They were all concerned that the project should continue in the area to encourage them in their work, as none received regular supervision from the Health Post staff.

Is their workload reasonable?

Yes, but the difficult terrain makes the work of the volunteers hard. They are understandably reluctant to walk very far from home.

How many days of initial training and how many days of refresher they received since the start of the project?

Early in Year 1 the project assessed the literacy status of the CHVs. Only 6 out of 45 CHVs in Ilaka 1 were found to be literate. Literacy education of CHVs in all three Ilaka has been undertaken.

CHVs have received their initial training days from the Ministry of Health. 104 CHVs have received 2 day refresher training on diarrhea and mobile clinics; 91 CHVs have received a 2 day training on AIDS; 103 CHVs have received a 2 day training on ARI; 30 CHVs have received training on STDs/AIDS; 66 CHVs have received a 2 day training on reporting and recording; 20 CHVs have received a 2 day training on control of diarrhea1 disease and nutrition.

40 TBAs received an initial training of 10 days using the curriculum designed by the MOH. 49 TBAs have received 4 day refresher training covering problems and reporting procedures; 29 TBAs have received 1 day training on STD/AIDS.

13 Traditional Healers have received a 2 day training on AIDS;
59 Healers have received a 4 day training on control of diarrhea, ARI, and STD/AIDS.

104 Basic NFE facilitators have received 10 days initial training, 95 received 4 days refresher training. 62 Advanced NFE facilitators have been trained. 52 Facilitators have received 9 days training for Out-of-School classes.

Is there evidence the PVO carried out a needs assessment before embarking on initial and refresher training?

A training needs assessment was carried out based on the data from the baseline survey to develop the curricula for the training of health workers. At the start of each training course all trainees are given a pretest and together produce a verbal list of expectations of what they would like to learn from the course.

Was the training methodology appropriate for the nature of the health workers jobs?

Yes, the training methodology used by SC/US staff, as indicated in their carefully-prepared training curricula (outlined in Quarterly Reports), is appropriate. It is participatory, suitable for both literate and illiterate participants using demonstrations, role plays, story telling, discussions, models, flip charts, real objects etc.

Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

Community Volunteers interviewed and observed by the MTE Team seemed competent and knowledgeable about their tasks. Most wanted further training in different aspects of their work. The project plans to have quarterly meetings with the volunteers using their work, its successes and problems as the basis for discussion.

The training of the NFE facilitators is the same length as for facilitators in other projects. Extra training was given to the Facilitators in Ilaka 13 who had had less schooling.

5.5 Supplies and Materials for Local Staff

The Ilaka offices and residences are a great credit to the staff. The buildings are rented from local people, the equipment locally purchased or from Kathmandu. They are clean and tidy.

The offices and residences seem reasonably well equipped for the staff to carry out their duties. The Team recommend that all Ilaka offices have good quality typewriters and that consideration is given for a computer to be installed at the office in Samundratar to enable word processing of reports and accounting. Although there is no main electricity computers can run on solar power or batteries. It is wasteful in time for experienced staff to hand-write reports.

Health staff who are involved with diagnosis and treatment at mobile clinics should be supplied with necessary equipment required for triage.

The stores inventories and ledgers are kept properly, though it may be useful to have a simplified system for Ilaka storekeeping.

The Stores Officer based in Kathmandu is responsible for all items purchased by SC/US. There is a comprehensive system for purchase, despatch, and storage of goods. A register is kept of items allocated to individual staff. The Stores Officer has a wide-ranging job description which includes purchase, monitoring of procurement, record keeping and training of impact area staff. Inventory checks are undertaken twice a year in Kathmandu and the Impact Areas.

The Stores Officer keeps a register of all capital items purchased. He is able to identify which grants have been used for the items, however he is not able to identify those items purchased by SC/US matching funds for particular grants. It is not clear to the MTE Team whether this would be a requirement of A.I.D.

The Team feel that the workload of the Stores Officer is very heavy.

The stores in the project Ilakas are in need of some attention, requiring racks for storage, plastic sheeting to keep booklets etc. clean.

What educational or other have been distributed to workers? Do these materials or supplies give any evidence of being used? Are they valued by the health workers? Are they appropriate to the health worker's job?

Some IEC materials have been developed by the project, others have been adapted from other SC/US programs and use is made of materials produced by the MOH and other NGOs. The few CHVs observed by the Team were using their flip charts well.

See section 5.3 for details of IEC materials and NFE materials.

Do the local staff have the necessary materials, supplies and equipment to carry out their current responsibilities?

The local staff did not suggest to the MTE Team the need for other materials, supplies or equipment. They are supplied with a range of items to enable them to work in the project area, such as sleeping bag, day pack, torch light, batteries, stationery.

Lanterns should also be provided for Out of School classes if they take place in dark rooms.

A.I.D. should note that the policy of restricting the purchase of Chinese goods from CS grant funds has caused great difficulty in purchasing simple goods such as torches, batteries, towels and pencils as only Chinese-manufactured items are available in the local shops.

The project should examine the quality of the paper used in the literacy workbooks and notebooks. The quality is poor and they become damaged very easily.

5 . 6 Quality

Do the local project currently have the technical knowledge and skills to carry out their current child survival responsibilities?

The local project staff seemed confident and competent but overstretched.

All of the project staff have attended a 5 day workshop on Quality Assurance.

There is good planning of project activities. Each Ilaka office displayed schedules for monthly and quarterly individual and program activities. It seems clear as to who is doing what, where, when and how.

Until recently only doctors were trained in Nepal in diagnosis and treatment of disease. Recently this has been included in the curriculum of nurses though they may get limited experience during their training. The project staff nurses are undertaking diagnosis and treatment of patients during the mobile clinics. The MTE Team were concerned about the staffs' competence in this.

A careful balance is needed between providing treatment for illness and education for prevention. Occasionally staff are asked to treat acutely sick children. These have to be referred to the health post or Kathmandu as project staff have limited medications and are not supposed to be providing a treatment service. This is difficult for caring staff who are qualified but ill-equipped but appropriate given the project's objectives. It would be valid for staff to follow up with mothers of sick children to check that the child has recovered, and to use the recovery as an educational example of the usefulness of appropriate treatment.

The MTE Team observed varying competence in teaching by the NFE facilitators. The Team appreciate that it has been difficult to recruit NFE facilitators in some areas but care must be taken to ensure that all facilitators are competent. If there is doubt about a teacher then it is not a question of 'someone is better than no-one' as a poor teacher is off-putting to the participants. Extra training and teaching practice should be given if necessary.

Do the local staff counsel and support mothers in an appropriate manner?

Project staff admit that counselling skills are weak amongst volunteers and staff dealing with mothers and STD/AIDS sufferers. The MOH has recently revised the curriculum on counselling for health service staff. SC/US will liaise with MOH and use the curriculum to train staff.

5.7 Sup rvision and Monitoring

What is the nature of supervision and monitoring carried out in this project? Is it field-based supervision?

The Team commend the project on the supervision that it provides to the staff and community volunteers. The close monitoring and careful supervision clearly motivates the staff. This is a lesson to be learned by the MOH.

Each of the 3 Ilakas in the CSVIII project area has one Ilaka team comprising a Field Coordinator (Ilaka in Charge) and other sectoral staff (health, NFE and productivity). The Field Coordinator provides immediate supervision to the other Ilaka staff. Additionally the Project Coordinator provides supervision to all staff, and the Field Accountant is based in the project area and visits each site every month. Locally hired staff are supervised by their respective sectoral project staff. The Field Coordinators have limited time to supervise activities as they are involved with administration, financial reporting and storekeeping. It would be helpful for them to have some support for this work to enable them to spend more time supervising project activities.

The Kathmandu Program staff provide overall supervision of the entire project in Nuwakot visiting an average of twice a year. The SC/US field-based project staff felt that supervision from Kathmandu staff had improved recently.

Field Coordinators and Project Coordinator meet monthly. Project staff meet every quarter to discuss the accomplishments made against the objectives during the past quarter and to set objectives for the forthcoming quarter. The meetings help to prepare quarterly reports and plan activities.

The NFE Coordinators visits lo-15 classes per month, the NFE supervisors visits each class in their area twice per month. The supervision schedule is written and agreed. NFE supervisors walk to the Ilaka office to meet with NFE Coordinators every Sunday to report, plan and discuss problems.

NFE Supervisors and health staff supervise facilitators and volunteers using a checklist.

Health staff have tried to arrange meetings with CHVs every 3 months.

Has supervision of each level of health workers been adequate for assuring quality services?

Yes, there is strong SC/US supervision of field staff, who work competently. The Project Coordinator is to be particularly commended for his energy and enthusiasm in regularly visiting and encouraging staff in all three Ilaka.

Supervision of all NFE facilitators and community volunteers is difficult given the terrain and the few staff.

The Team feel that more attention should be paid by the SC/US senior staff in planning and carrying out briefing and orientation of new staff at all levels. More care should be taken to ensure that individuals are settling in to their new roles and that further briefing is given if there are areas of difficulty.

The MTE Team also suggest that SC/US consider more carefully the problems raised by moving members of staff from one work area to another. Success of this type of project in such a remote project area relies on project staff building good teams. It is important not to overlook that whenever a member comes or goes the nature of a team changes and time must then be spent in team building again. This loses impetus for project activities.

The MOH has recently developed a Quality Assurance Checklist. The MTE recommend that the MOH is requested to share this with NGOs.

From the viewpoint of the health and other project workers, how much of the supervision is counselling/support, performance evaluation on-the-job education or administration?

The project staff felt that the field level supervision they received was an appropriate balance. The supervision from Kathmandu would seem to be more performance evaluation and administration.

What are the monitoring and supervision requirements for the remainder of the project?

In December 1993 the project staff developed a table indicating the various grant management requirements for the project (attached in Appendix 7). This gives a comprehensive list of activities, frequency of input and allocation of responsibility. It would be much improved by the addition of a Gant plan (bar chart) to indicate when the activities will occur in respect to each other and each staff member for the next year. This will help to identify key events, milestones and deadlines, examine dependency and workload of activities, exercise time management, and work out priorities.

5.8 Use of Central Funding

Have administrative monitoring and technical support from the PVO regional or central offices been appropriate in terms of timing, frequency and needs of the-field staff? If not, what constraints does the project face in obtaining adequate monitoring and technical support from PVO regional or central offices?

The project staff felt that they had received reasonable technical support from the PVO headquarters. The project welcomed the visit from Donna Sillan to help with the DIP.

The project staff would welcome speedier returns from the Kathmandu accounts office.

How much central funding has A.I.D. given the child survival for administrative monitoring and technical support for the grant? Do these grants serve a critical function? Does this function appear to be underfunded or overfunded?

The Home Office portion of the funding for the Nepal Field Office CSVIII totals $5 1,402 over the three years. The breakdown of expenditure was not available to the MTE Team.

Are there any particular aspects of A.I.D. funding to the central office of the PVO that may have a positive or negative effect on the meeting of child survival objectives?

This was not assessed by the MTE Team.

Changes to the Cooperative Agreement seems to take an unduly long time to be resolved. There was a general feeling among the senior project staff that the CS funding is too target-oriented and does not allow enough flexibility to be innovative. It would be useful for A.I.D. to enable projects to respond to ideas and needs providing they are justified and reported clearly. Perhaps a percentage of funding should be unattached.

5.9 PVO's Use of Technical Support

What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained?

Technical assistance has been obtained as follows:

* Donna Sillan from the SC/US Regional Office assisted with the preparation of the DIP.
* Katherine Kaye from the SC/US Headquarters Health Unit commented on the MTE cluster survey results.
* Kim Wylie, Asia Desk Officer from SC/US Headquarters, was a member of the MTE Team (paid for from Central Funds).
* Dale Davies from the Helen Keller Int'l. Foundation provided Vitamin A training.
* Dr Davendra Panth, from the Tribhuvan University Teaching Hospital and Dr Sanoj Prasad from Nepal National AIDS Control and Prevention Project assisted with the STD Camps.

* Two Traditional Birth Attendant (TBA) trainers from the District Public Health Office in Nuwakot assisted with TBA training.

* Karuna Yonjon from Seto Gurans helped with training on Home Based Child Care Centres (HBCCC).

* Dr Keshav Dungana, from the District Public Health Office assisted with the Vasectomy Camp.

* Striva Shankar Baniya from the Cottage and Small Industry Development Board (CSIDB) gave orientation about Women's Savings Groups.

* Cynthia Carter, Child Survival Support Project, Johns Hopkins University assisted with the design of the 30 cluster sample survey (Mid term survey).

* Min Dhoj Karki worked for two months as IEC consultant (he has since been employed as full time IEC Coordinator).

* Charles Pradhan, an independent consultant undertook the qualitative research on Knowledge, Perception, Attitude and Practices of Oral Rehydration Solution, Immunisation and Family Planning.

Was the level of technical support obtained by the project adequate, straight-forward and worthwhile?

The project staff have appreciated all the technical assistance received to date. They emphasised that the assistance has not only rendered a service but has been an excellent opportunity for project staff to upgrade their knowledge and skills and to review the activities of the project with an expert.

Are there any particular aspects of the technical support (from all sources) which may have had a positive or negative effect on meeting project objectives? (For example, consultant visits, evaluation, workshops, conferences.

Technical support and attendance at conferences have all had a positive effect.

Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

Future technical support required is: two doctors to assist with STD camps in Year 2; a consultant to assist with reviewing the effectiveness of treatment for ARI by the Village Health Workers using case-control studies; a consultant to assist with a study to assess the impact of health messages in the NFE classes. There are no constraints in obtaining this assistance: it should be available in Nepal.

5.10 Assessment of Counterpart Relationships

What are the chief counterpart organizations to this project? What collaborative activities have taken place to-d&!

The Ministry of Health, the Ministry of Education and Culture, and the community management committees are the main counterpart organisations.

In March 1993 a 4 day workshop was held to initiate the MCH Mobile Clinics, attended by project staff and Health Post in Charges from Salte Maidan, Rautbesi and Shikharbesi Health Posts. Additionally a meeting was held with local CHVs. This workshop defined the role and activities of the Mobile Clinics, and developed policies. (Full details are in the report attached to the January-March 1993 Quarterly Report). At the workshop it was decided that mothers groups would act as the Mobile Clinic Management Committees.

The MOH provide staff and vaccines for the cold chain. Meetings have been held to analyse the problems of the cold chain, a protocol developed and improved services arranged.

STD camps have been organised with the collaboration of the DHO, the Women's Rehabilitation Centre (WOREC), and the National AIDS Control Project. The Institute of Medicine has provided doctors for the AIDS/STD camps. Other health activities are carried out with the MOH.

The Ministry of Education undertakes NFE in three areas of the SC/US project area. The project carries out NFE in all areas in coordination with the MOE. The materials for the NFE classes are provided by the MOE. The MOE District staff appreciate the quality of the SC/US project work; they suggest that its strength is in its close supervision of NFE facilitators. The Project coordinator visits the District DOE office regularly, and the DOE officers have visited the project site.

Additionally SC/US works closely with WOREC, an indigenous NGO, in AIDS education and care, and with the Helen Keller International Foundation on developing strategy for Vitamin A deficiency control.

District officials (CDO, DHO and Education Office) were satisfied with the work being done in the project area. The CD0 emphasised that he had heard only good of the SC/US project staff and that they were behaving well in the area.

There is good coordination with the Ministry of Health, the Ministry of Education, and the CD0 at District level. More effort could be made to inform and work with the Ministry of Health headquarters officials.

Linkages are also good with the District Forestry Office.

Are there any exchanges of money, materials or human resources between the project and its counterparts?

The MOH provides health workers for the EPI, for some camps and promotion activities. The MOH provides vaccines, Vitamin A, ORS and contraceptives.

The MOE provides textbooks for NFE classes.

The District Forestry Office provided 10,000 tree saplings which were planted by NFE participants and Women's Groups.

SC/US provide kerosene to maintain the cold chain to Kaule and Samundratar Health Posts. SC/US has assisted in moving a freezer to Samundratar Health Post.

Do the counterpart staffs have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?

Some of the MOH staff who are working in the project area are frequently absent from their work station. It is difficult for the community and the project to rely on them to provide the EPI and referral services intended. The MOH staff at Region and District level are sympathetic and knowledgeable about the problems and would welcome information about absenteeism and poor work. SC/US staff rightly feel that it is not their responsibility to supervise the MOH staff. However the MOH and SC/US and the community all agree that it is the role of the community to demand the services from the MOH and to report poor services. The project can assist the community leaders to have a dialogue with the MOH.

The MOE and MOH are acutely short of staff and funds to take on the child survival activities.

Is there an open dialogue between the PVO project and co-arts?

Yes, frequent meetings are held between the Project Coordinator and the District-based officials, with the Public Health Coordinator and MOH headquarters officials.

Ilaka health staff meet with project staff at the mobile clinics. However there seemed to be few regular planning meetings with the Health Post staff, mainly because they were rarely in post. It is important to keep trying to involve the Health Post staff in planning health activities with the community.

There is a fairly fast turn-over of staff in the District headquarters. The CD0 will be moving soon, the LDO is new. The present CD0 was full of praise and was very knowledgeable about the project; the LDO knew little. SC/US needs to keep the dialogue going, ensuring that new government officials are briefed about the project, are invited to the project area and are given copies of project reports and materials on a regular basis.

5.11 Referral Relationships

Identify the potential referral care sites and comment on access and service quality. Has the project made appropriate use of these referral sites?

The referral sites for health for the project area are the four health posts: Salle Maidan health post in Ilaka 1, Shikharbesi and Samundratar health posts in Ilaka 12, and Rautabesi health post in Ilaka 13. All these health posts are at least a day's walk from the District Hospital.

These health posts are inadequately staffed and poorly supplied with equipment and drugs. The buildings are in a poor condition. No health post has had a Health Post In-charge working for a very long time. Some have an Assistant Health Worker; in Rautbesi there had only been two peons for six months. The peons often care for and treat the sick.

The project's many health promotion activities refer people to the health posts for treatment of illness, for antenatal and family planning services, for difficult labour and for immunisation. There are rarely appropriate staff or sufficient drugs available for referred cases to be dealt with properly. Without improving the referral sites it is unfair to recommend people to walk many hours with little hope of effective care.

Since the MOH reorganisation the EPI service has been very poor.

What is the continuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate?

Those staff who do work at the health posts are appreciative of the work of the project, the training they have received and the interest of the staff. They report an increase in the number of people coming for treatment. They are deeply frustrated by their lack of supplies.

The Assistant Health Worker at Samundratar in Ilaka 12 said that with the close involvement of the project he felt more encouraged to be at his health post and that the community are using his services more. He and the In-Charge from Ilaka 1 both felt that as people have become more confident with the medical services from the mobile clinics then community people are using the health posts more also.

Is the project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

The project is working closely with the DHO to encourage staff to work at the health posts as deployed. MOH staff are encouraged to attend SC/US training courses. There are regular meetings with health post staff.

The Public Health Coordinator of SC/US has encouraged the MOH to designate Nuwakot District as a Safe Motherhood District, hence obtaining funding from WHO to strengthen the district hospital for referrals in obstetrics and gynaecology.

The health posts are all old and decaying. The Team feel that health posts should be models of cleanliness in the community. The Health Post Committee and local people should be encouraged to assist the health post staff in cleaning and renovating the health posts and constructing of a latrine. The project could consider providing funds towards this. This may also encourage the health post staff to work there.

The project should consider providing funds to set up a revolving drug scheme at the health posts for essential drugs.

The MOH plans for sub health posts should be supported by the project if the community are enthusiastic to provide contributions.

5.12 PVO/NGO Networking

What evidence is there of effective network& with other PVOs and NGOs working in health and child survival?

The Local Development Officer has tried to hold coordination meetings of NGOs working in the District without success. Most meetings are informal.

SC/US has strengthened its relationships with a number of NGOs working in the health sector:

WOREC is working in the project area in AIDS prevention and care.

Helen Keller International Foundation staff member provided the technical assistance for Vitamin A training.

Seto Gurans has provided technical assistance and training on early childhood education.

ABC Nepal has assisted with street drama on STD/AIDS.

ADRA, SCF(UK) and Redd Bamna are involved with SC/US in an alliance project to develop a Safe Birthing Kit with SC/US as lead agency.

Sida Bikas Kendra Creative Development Centre has worked with some of the Women's Savings Groups.

CARE, Plan International , Action Aid, Lutheran World Service are interested in using the IEC materials developed by the project.

SC/US are encouraging regular meetings of PVOs.

There are many NGOs who are using literacy materials developed by SC/US or who are receiving Technical Support from SC/US, NFO, Education Section:

1. Britain Nepal Medical Trust
2. ADRA
3. CARE/Nepal
4. Save the Children/Japan
5. USC, Canada
6. United Mission to Nepal
7. Save the Children/UK
8. IIDS
9. Danish Volunteer Service
10. Redd Barnna
11. DISVI
12. Devres/New Era/Winrock
13. Swiss Development Cooperation
14. v s o
15. Action Aid, Nepal
16. Lutheran World Service, Baglung
17. Lions Club, Gorkha
18. Janakpur Women's Development Centre
19. BASE
20. Glory Foundation
21. World Education
22. Tulshi Mehar UNESCO Club
23. WID Nepal
24. Kailali Community Development Project
25. Annapuma Conservation Area Project
26. Nari Bikash Kendra, Nepalgunj
27. Dhading District Development Project
28. Creative Development Centre
29. Nepal Red Cross Society
30. Women Development Section, Gorkha
31. Primary Education Project, MOE
32. Women's Education Unit, MOE

Additionally SC/US is working in partnership with three Nepali NGOs on literacy: BASE, NNSWA and CERID.

With the support of a grant from AmFAR SC/US is providing technical assistance to 17 Nepali NGOs working throughout Nepal on HIV/AIDS prevention, treatment and care.

Are there any particular aspects of the situation which may have a positive or negative effect on networking?

Networking with local NGOs is difficult given the terrain in Nepal. It is hard to have regular meetings with people who are many hours' or days' walk away.

Can the project cite at least one lesson learned from other PVOs or from other child survival projects?

1. The multi-sectoral, integrated approach to Vitamin A as promoted by Helen Keller International Foundation has been a useful lesson incorporated into the project.

2. The project has learned many lessons from earlier CS projects undertaken by SC/US such as the use of street drama (from CSIII), the use of focus groups (from CSVII) and the wide variety of IEC materials and methods (from both CSIII and CSVII).

The project staff are good at picking up good ideas/lessons learned from other projects.

5.13 Budget Management

How does the rate of expenditures to-date compare with the project budget?

The rate of expenditure of the budget is low. Virtually all line items (except evaluation) are underspent. Travel and communications were over-budgeted given that the terrain makes communications difficult and walking the only means of getting around in the project site.

Is the budget being managed in a responsible, but flexible manner?

The MTE Team are concerned about the depth of understanding that project staff have about the budget. Field staff need to have a better feel for the available budget when they are planning activities and writing Field Office reports. Senior staff should be clear about budgets and expenditure. The project staff are to be congratulated for attempting to keep project costs down but they should be encouraged to use the money allocated so that more project activities can be carried out.

There has been some past confusion amongst senior staff about who should be making decisions about capital expenditure, and what or if capital assets have been planned or purchased under the grant. These decisions should be undertaken by the Public Health Coordinator in discussion with the Project Coordinator and the Budget Manager.

Accounting systems are appropriate and grant expenditure can be tracked.

With the expansion of the NFO program there is considerably more work for the Accounts Department. The Accountants seemed to be under great pressure. Program Officers feel that it is difficult for them to find time to meet with the Accountants.

There is a Field Accountant in Samundratar; it would be helpful to hire part-time bookkeepers in the other Ilaka offices to enable Field Coordinators to spend more time on overseeing project activities.

The Field Accountant should be regularly kept informed of Kathmandu expenditure so that he has a feel for the totality of the budget.

The MTE Team are concerned that it is difficult to track expenditure in the project assigned to matched SC/US Private funds, and the same degree of analysis of under/over expenditure is not possible for private funds as it is for grant funds.

Can the PVO justify budget shifts that may have occurred?

Budget shifts and under-expenditure in Year 1 were not reported in Section V of the Year One Annual Report. This was due to a misunderstanding between the NFO and the SC/US Head Office, each believing it to be the role of the other.

The project staff have explained the under-expenditure to the MTE Team as follows:

The posts of Ilaka 13 Staff Nurse and of IEC Coordinator have been difficult to fill. The former is still vacant, the IEC Coordinator joined only in April 1994.

Failure to recruit an IEC Coordinator and a delay in obtaining qualitative research data has delayed the development and production of IEC materials.

Local staff were not recruited until the middle of Year 1.

Project staff salaries were initially charged to private rather than grant funds.

Start-up activities of the project (office establishment, base-line survey, preparation of DIP, recruitment of staff) took longer than expected, hence travel for project activities were delayed until mid Year 1.

Some office establishment costs in the original proposal were made using SC/US Private Funds before the beginning of the grant.

Expenditure on the line-item for 'express mail' has not been possible as there is no reliable postal service to the project area. Post is hand carried from Kathmandu by project staff or messengers.

The balance remaining from under-expenditure of the grant in Year 1 was carried forward into the following grant year.

The cost of external evaluators is underestimated. The Final Evaluation budget should be higher. Evaluations take longer in Nepal than in countries where the terrain is easier. Walking

time must be calculated in and a longer period allowed for the evaluation.

Can the project achieve its objectives with the remaining funding?

Funding is not the main constraint to achieving project activities. Time is the key factor in this project.

It is likely that objectives wholly reliant on project staff activities can be achieved by the funding. It is unlikely that objectives that rely on the inputs from the MOH (such as EPI and Vitamin A) could be achieved.

Is there a possibility that the project will be underspent at the end of the project?

If the MTE recommendations for extra staff for health promotion, more promotional activities, speedy production of IEC materials and some support to the referral centres, and a no-cost extension for three months are undertaken then it is unlikely that the project will be underspent.

Health service and NFE participants have to pay a minimal charge so as to maintain and promote a purchasing habit.

SC/US has started work in Nuwakqt on the understanding that it will require more than 3 years to develop sustainable development activities. In its experience in Gorkha District'9 years is a more feasible duration to raise awareness, change attitudes and hence change behaviour. SC/US will be trying to raise funds to continue key work with the communities for some years more after CS project funding ends.

Are the incentives received by community volunteers, project staff. meaningful for project commitment?

All community volunteers and project staff seemed satisfied with their incentives. All seemed very committed.

All incentives and allowances for volunteers and MOH staff are at the government rate. Commitment seems to come through encouragement.

NFE Facilitators receive Rs 525 per month.

Would these incentives continue once A.I.D. project funding ends?

Incentives presently paid by the MOH would continue, all others would cease.

How is the community involved in planning and implementation of project activities?

The community has been well involved in the planning of project activities. In November 1992 a two day planning meeting of 25 local leaders from 14 VDCs helped to define the program activities according to the community's priorities of literacy, health education, health services and controlling of girl trafficking. Orientation meetings were held before developing the project proposal. Community members were involved in meetings. to choose the sites of mobile clinics, NFE classes etc.

The communities elect their members of the MCH Clinic Management Committees. These Committees are strong and resourceful, and are taking decisions based on discussions with the community and project staff.

A village meeting is held in each area when planning NFE classes. The NFE Supervisors aim to convince adults to join the classes, and the parents/guardians of children of the importance of school or Out-of School classes.

Local leader coordination meetings are supposed to occur quarterly, and this is usually achieved. Regular meetings are held with VDCs. VDC members met by the MTE Team were all aware of and involved in project activities.

Community members have been involved as interviewers during the baseline and MTE surveys.

The Women's Savings Groups are being formed. Some are keen and active, particularly in Ilakas 1 and 12. The interests of the members govern what activities will be carried out.

Do community members see this project as effective?

Yes. There is widespread awareness of the project amongst the general community. Community leaders, government workers and project staff report an increased awareness of health issues and of the importance of educating women. The Chief District Officer reported that he had heard nothing but good from people in the project area.

There is an increased demand from the comrnumty for health services and for formal and non-formal education for both children and adults, reported by the MOH staff, the private medical shop and the school teachers. Women attending the NFE classes are pleased to have the opportunity and feel that they are learning about a wide range of issues.

Parents like the Out-of-School class as the children are keen, and are motivated to be clean.

Project staff do feel that they underestimated just how conservative the Tamang community are. However an increased number of Tamangs are becoming involved.

The MTE Team feel that the Project staff are working well in the community, slowly and carefully building up trust and confidence. The community seem to believe that SC/US will work with the community to provide what they have promised. There is a sense of credibility.

The project staff need to emphasise more the need for community self-reliance, in order for the community leaders and groups to understand that it is up to them to work together to demand services from the government and to work together to generate or apply for funding for development activities.

Is there a demand m the community for the project activities to be sustained?

Yes. Community members and leaders interviewed by the Team emphasised their commitment to the project and their desire for activities to be sustained and expanded to increase awareness of health and the education of women.

One VDC Chairman said "the project is opening the eyes and minds of our women".

The multi-sector approach incorporated in project activities and in the NFE materials is appreciated and ensures that there is something for all interests and hence reduces drop-out.

Do local organisations see the project as effective?

Yes, local organisations see the project as effective, but all appreciate that it is only just starting.

Are there any concrete plans for project activities to be institutionalised by local NGOs?

An Impact Area NGO Strengthening Committee (IANSC) has recently been formed by the project staff. They have initially identified local clubs and NGOs and hope to be able to involve and support them with technical advice in health and education activities.

STD/AIDs activities may be sustained by WOREC, a local NGO that will continue to work in the area. WOREC presently is in receipt of funds from AmFAR and others.

Is the MOH involved in the project?

The MOH is crucially involved in this project as outlined above. It does provide EPI, vitamin A, contraceptives and training of its staff. The District Health Officer is now in charge of both the hospital and community services. There are insufficient staff, materials and supplies in the hospital and health posts. The DHO is unable to adequately cover the remote areas.

Does the MOH see this project as effective?

The MOH staff at local, District and National level do see the project as effective. They appreciate that its success relies significantly on their improved and continued contribution. The DHO feels the mix of activities is sufficient and is impressed with the SC/US staff, particularly their commitment to working in remote areas. The DHO would like more coordination meetings with the project and with other NGOs working in health. He sees the strength of the project in increasing community participation.

Are there any concrete plans for the MOH to continue particular project activities after funding

The MOH is aware that the project relies on the MOH commitment to supply EPI, family planning and Vitamin A services. If the MOH does not continue to supply these there is no other feasible source.

7 Recurrent Costs and Cost Recovery Mechanisms

Do the project managers have a good understanding of the human, material, and financial inputs required to sustain effective child survival activities?

Now that the project staff have experience of working in the project area, the project managers need to more fully analyse the human, material and financial inputs required for sustainable activities. This should be presented in the Year 2 Annual Report.

What is the amount of money the protect calculates will be needed to cover recurrent costs?

The project should present this calculation in the Year 2 Annual report.

Do the community agree to pay for any part of the costs of preventive and promotive health activities?

This is an extremely poor community. It has been difficult to get any community agreement on paying for health services as for years the Government has said that these would be free. Individuals rarely allocate money or save money for health care.

Those that are participating in project activities are contributing towards costs. In the health sector the community people pay for the cards required to attend the MCH Mobile Clinics. Pregnant mothers pay Rs.2 ye&y, a Child Card (for children under 5 years) is Rs.5 yearly. A lost card requires a replacement fee of the same amount. In the NFE sector there is an admission fee of Rs .5, a monthly fee of Rs. 1, and Rs.3 per book.

The community are also committing a great deal of time and energy in shadow costs. NFE participants attend for 2 hours an evening six days a week for six months plus time for health promotion activities. Children give two hours each morning for six days a week for 9 months. Visits to the MCH Mobile clinics may take up to two hours walk and a long wait.

Focus Group research should be carried out to find out what services people would be prepared to pay for, how much they could afford to pay and how much they would be prepared to pay.

Is the Government prepared to assume any part of the recurrent costs?

The government is keen to be able to achieve its obligations. SC/US and this project are doing its best to influence MOH and MOE policy at national level and to encourage district level services.

What strategies is the PVO implementing to reduce costs and make the project more efficient?

The MTE Team feel that the staff are keeping project costs to the minimum. The project could

increase its costs to be more efficient by having more support staff. There are economies of scale possible by increasing the number of Ilaka staff involved in health promotion.

The project uses government policies for payment of incentives. The project tries hard to recruit local staff and to use local resources. This is a low technology project, there are no sophisticated technical equipments used. The PVO uses materials and staff from the government whenever possible. The project is using IEC materials produced by the government and other agencies where possible.

What specific cost-recovery mechanisms are being implemented to offset project expenditures?

None. The money received for health is collecteclllnd used by the community MCH Management Committees. The fees from NFE classes go to the Women's Groups which they use for income-generating activities or to improve their locality. Project staff consider that it is too early in such a project to develop -cost-recovery mechanisms. There is further need to raise awareness of health issues and foster an interest in the use of health services.

Project staff will discuss mechanisms for revolving funds etc with community groups in the next year. There is a plan for the Health Posts to charge Rs.2 per consultation which is beginning to get some agreement from the community but it will rely on the Health Post staff being convinced and motivated to work regularly.

Are costs reasonable given the environment in which the project operates; is the cost per potential beneficiary appropriate?

Yes, given the environment the costs are reasonable. Total expenditure so far, including start up costs, is about $6 per potential beneficiary.

Identify costs which are not likely to be sustainable.

Project staff should identify these for the Year 2 Annual Report.

8. Recommendations

What steps should be taken by the PVO fields for the project to achieve its outputs and outcome objectives by the end of the project?

1. The project team should continue the excellent work that it has achieved.

2. The project team should consider whether to prioritise its interventions and reduce the number of objectives or activities.

3. The project should continue to try to hire additional staff, such as MCH workers, and use short term consultants for IEC activities such as drama, to increase health promotion activities. Extra staff are needed to work in the more remote areas with the high risk groups, particularly in AIDS/STD and family planning.

4. Further emphasis is required on strengthening the MOH activities such as MCH Mobile Clinics. The Mobile Clinics should continue bimonthly in each area. More efforts should be made to ensure EPI teams attend. More creative educational activities could be carried out at the Clinic sites. A greater sense of ownership by the MCH Mobile Clinic Committee should be encouraged. Further ways of raising funds, but still enabling access by the very poor, should be examined.

5. The MOH Health Posts, the referral centres on which the project area relies for acute curative services, must be strengthened. Treatment for key child survival diseases such as ARI and diarrhea must be available.

6. Greater efforts should be made to encourage the building and use of low cost household latrines for the prevention of diarrhea.

7. More encouragement should be given to CHVs, shopkeepers and families to keep a stock of Jeevan Jal for preventing and treating dehydration.

8. Educational activities should be increased to improve the knowledge and practice about Vitamin A rich foods and ARI.

9. A useful staff addition would be to recruit an agriculturalist to work with the groups on kitchen gardens and cash crops. More effort should be made to liaise with the District Agriculture offices.

10. Family planning education and the availability of contraceptives should be increased. The team feel that temporary contraceptives should be made available from the mobile clinics and the CHVs. The project should explore the training of VHWs to give Depo Provera. Counselling skills for SC/US staff and volunteers should be improved. Staff should ensure that a place is available for complete confidentiality.

11. The "3 Cleans" of childbirth should be taught to all women (not just to TBAs and NFE participants) as many women deliver on their own or with only a family member present. More health promotion is required about TT if mothers are to use take up vaccination at the Mobile Clinics.

12. The project should try to work even more closely with the MOH in the development of IEC materials so that these can be used or adapted. IEC materials should be made of materials capable of withstanding very hard use, and carrying long distances.

13. It would be better, perhaps, to start with fewer NFE classes in new project areas, so

that the community can see how the classes work and can be convinced of their usefulness.

14. A brief memory-aid could be developed for the NFE facilitators of the key 'musts' in participatory teaching.

15. The project should have a more intensive program of parenting education to raise awareness of the need. It may not be feasible to continue work on HBCCC until this is done. Longstanding childcare practices are notoriously difficult to change.

16. Local community women should be involved in the Child-to-Child classes so that they can conduct the classes in the future.

17. The project may find it useful for Ilaka teams to keep systematic records of their regular meetings and meetings with local leaders in order to keep track of decisions made etc.

18. Quarterly reports should relate the activities reported to the activities planned in the previous report and particularly to the project objectives so that it is clear why particular activities are being carried out.

19. Plans for activities for Year 3 should be included in the Year 2 Annual Report. A response to the queries about objectives and indicators raised in Section 5.2 should be included in the Year 2 Annual Report.

20. The design of the final survey must enable comparison of achievements to all objectives, in addition to carrying out the standard A.I.D. Final Survey.

21. Given the difficulty of undertaking a survey in the monsoon it would be more appropriate for the Final Survey to be undertaken after Dasain and Tihar in November 1995. The Final Evaluation could then be undertaken in December 1995. The MTE Team recommend this timing. The Team feel that this extension of the project could be funded out of existing project funds and would require a no-cost extension only.

Are there any steps the project and PVO headquarters can take to make the project activities more sustainable?

22. Project staff, community leaders and district health and education workers now have experience of working in the area and a good idea of what is working well. It important to develop a clear phaseover plan, to cover all objectives and activities to ensure that plans are made well in advance so as not to frustrate or disappoint the community. A clear phaseover plan should be included in the Year 2 Annual Report.

23. Work should start now with the various community groups, such as the MCI-I Mobile Clinic Management Committees, to plan the phaseover strategy.

24. The project's strength lies in its ability to involve the community. More emphasis could be made on the community's input to revive the MOH system and motivate the MOH staff.

25. The project should work more with the community leaders and Groups to develop their self-reliance and ability to generate funds for development projects. The project staff should work more with the Women's Savings and Mothers Groups to help them appreciate that the activities are for them and their families not for Save the Children/US.

26. The project needs to continue to develop creative ways to brief, involve and report to District government officials, Ministry of Health and Education District staff in order for them to feel a sense of ownership and responsibility to the project and hence to ensure that their inputs into the project activities are sustained. Regular meeting times should be arranged, and followed up if missed. Shorter project summaries are more likely to be read.

27. The MTE Team members from the MOH felt that more effort should be made to continue to involve MOH staff. Because of the recent frequent changes in staff at the MOH headquarters the project will need to keep briefing new staff. The Team felt that SC/US should renew their efforts to coordinate with the MOH and vice versa; the MOH clearly has many skilled and committed staff and more attempts should be made to involve them. The commitment expressed by the government should be shown by a sense of ownership of the project.

28. More needs to be done to improve the commitment and work of the VHWs and health post staff. If community involvement is forthcoming then funds could be allocated for some improvements to the health post.

29. There should be a representative of the Ministry of Education on the Final Evaluation Team.

Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the service Of higher quality?

The MTE Team feel that the design of project activities are fully appropriate to the project.

30. The MTE recommend that the project reviews the work of the health staff in diagnosis and treatment at the mobile clinics and that relevant staff have their training needs assessed and refresher training provided if necessary. It is essential to ensure that staff are competent to treat or refer. The project should ensure that the MOH guidelines for treatment by staff are fully followed.

31. New staff or changes in staff should be planned more carefully to enable better orientation and team building.

32. Pre-posting and in-post Tamang language training should be given to staff who require it.

33. Staff should have further training on budget monitoring and management. Staff need greater understanding of how to monitor the SC/US private funds as a match to the A.I.D.

funds. Some Ilaka staff felt that training on report writing would be useful: the MTE support this.

34. Project staff would benefit from a workshop to examine the project's issue of sustainability, cost recovery and institutional development.

35. Care needs to be taken that scaling up of activities by the PVO in Nepal does not cause the senior staff of NFO to be overstretched. The MTE Team felt that all staff were working to their capacity and occasionally it was hard for all the activities and projects being undertaken by NFO to be coordinated well enough in advance. There are so many demands on their time that urgent but unplanned activities interfere with their planned work schedules.
Changes in the size and structure of the NFO of SC/US will affect all staff. Changes need to be planned well ahead and staff enabled to participate in decision-making. It may benefit the organisation at this stage for senior managers to undertake training in the management of change.

36. The filing system should be reviewed to ensure that all documents and correspondence relating to the project are held securely in one place, perhaps with the Public Health Coordinator, and that a simple card system is used to indicate who is using a particular document. The Team recommend that the secretary hired and paid for from the CSVIII grant funds is used exclusively for the project.

37. All letters and memos relating to the CSVIII budget should be copied and kept on files of the Public Health Coordinator, the Budget Manager and the Accountants. They should regularly meet with the Project Coordinator to discuss implications of the budget and expenditure. Draft budgets should be agreed by the group and the PVO Headquarters.

38. The CSVIII MTE Team agree with the recommendation made by the CSVII Team in Siraha that expenses incurred in the Kathmandu office, which are attributed to the CS project, be transmitted to the accountant in the Nuwakot project office so that he has a more complete picture of expenditures by line item. A similar recommendation is made for expenses so incurred in the Westport office. The Nuwakot accountant should know all budget amounts and expenditures by line items to enable clearer financial management in the field.

> Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by A.I.D. or by the PVO?

39. SC/US is good at ensuring lessons learned are disseminated. This should be continued through wide publication of project results.

40. SC/US should document the lessons learned about working in the different Ilakas with different caste and cultural groups.

> Are there any issues or actions that A.I.D. should consider as a result of this evaluation?

41. The local A.I.D. Mission staff have been very supportive of the project, which is encouraging for the project staff. The Mission is keen that SC/US address the issue of girl trafficking. It is unfortunate that the A.1 .D. health representative has been unable to visit the project area or accompany the MTE Team. It would be useful for an experienced representative from the A.I.D. Mission to accompany the Final Evaluation Team.

42. Sustainability as the major goal is questionable for a project in a country with communities as poor as in Nepal. Donors looking for long-term sustainability need to provide long-term funding for developing strategies leading to sustainability. The three year time frame for the CS projects is unrealistic: many start up activities such as setting up an office and hiring health staff and gaining the community's confidence can take up to a year. It also leaves little room for flexibility in implementation, to respond to community interests, or to cover unplanned events such as staff turnover. The MTE Team strongly recommend that A.I.D. considers extending the time frame for its CS projects to 5 years.

43. Clearer guidelines on sustainability from A.I.D. would be useful. An example raised by project staff is that of A.I.D. promoting sustainability through strengthening the government, whilst also advocating that projects should be involved in service provision if the government is weak.

44. A.I.D. should improve the timeliness of issuing the Guidelines for carrying out Mid Term Evaluations. It is of little use to commence a three project in October, expect a MTE 18 months later (i.e. April of year 2) and only release the Guidelines in July of Year 2.

45. A.I.D. should either reconsider the standardised format of the baseline and mid-term surveys for its Child Survival projects or give clearer guidelines to projects during the proposal stage that objectives should be written in such a way that they are measurable using the format. It is confusing to have project objectives applying to women, men, children over 2 years, say, but to be restricted to surveys of women with children under two.

46. CSVIII projects have been required to submit Quarterly Reports to A.I.D.. The Team consider this to be excessive and that Annual Reports for A.I.D. should be sufficient. The Team appreciated the quality of the project's Quarterly Reports, and the staff stated that they felt that it was a useful exercise to produce quarterly reports. The Team recommend that the Project continues to produce Quarterly Reports for its own use and for submission to District counterparts, but that A.I.D. should receive Annual Reports only.

47. The MTE Team suggest feedback should be given by A.I.D. on reports submitted to it by CS Projects. In addition to responding to a DIP A.I.D. could respond to Annual Reports, Mid Term and Final Evaluations with examples of lessons learned from other countries.

Appendix 2 - Objectives for the MTE

1. To review progress being made toward achieving the proposed outputs, purposes and goals of the grant.

2. To resolve issues raised during the initial planning process but which could not be resolved until the implementation stage

3. To identify what is working well with the project.

4. To suggest areas of the project which need further attention.

5. To review management and financial accounting of the project.

6. To review the sustainability of the project.

7. To assist SC/US to assess the lessons learned.

8. To recommend useful actions to guide the staff through the last half of the project.

Scope of Work for the MTE Team Leader and Team Members

The team leader will undertake the following activities related to the CSVIII midterm evaluation (MTE):

a. Coordinate the activities of the MTE team during the period of the evaluation.

b. Review Save the Children US (SC/US) CSVIII project activities and related documents i.e. quarterly reports, survey reports and detailed implementation plan.

c. Meet key members of the SC/US CSVIII project staff in Kathmandu and Nuwakot to review the design, implementation, constraints and achievements of the project.

d. Review the CSVIII project activities with Ministry of Health officials, both in Kathmandu and Nuwakot, and others knowledgeable about the project activities.

e. Collect and analyse information on selected project aspects (family planning, EPI, Vitamin A, maternal health etc.) and develop those findings in a written format to fit the outline for the MTE report.

f. With the rest of the Evaluation Team develop a consensus on key findings and recommendations concerning the project.

g. Participate in the debriefing on the MTE with the SC/US project staff, SC/US NFO senior management, USAID local mission staff and senior Ministry of Health officials.

h. Coordinate the writing of the MTE report. The draft report to be submitted to SC/US by the end of May 1994.

The MTE Team members will assist the Team Leader in the activities as above a.- h..

Appendix 8

SAVE THE CHILDREN/US

NEPAL FIELD OFFICE
CHILD SURVIVAL 8
MIDTERM SURVEY REPORT

MARCH 1994

Cooperative Agreement No. FAO-0500-A-00-2034

September 30, 1992 - September 29, 1995

Save the Children
54 Wilton Road
Westport, CT 06880
(203) 221-4000

Acknowledgments

On behalf of Save the Children/US, we would like to thank the twenty five locally hired enumerators for their contributions in collecting survey data. Community people of Nuwakot, Save the Children/US Nuwakot-based staff deserve special thanks for their active involvement as survey supervisors and the contribution they made during tabulation and analysis of results.

We are grateful to Mr. Keith Leslie, Country Director and Mr. Bharat Mani Devkota, Program Director for the trust they have put forward for the survey.

Valuable guidance and encouragement provided by Ms. Chanda Rai, Public Health Coordinator boosted the confidence of survey team members. Special thanks goes to Ms. Naramaya Limbu and Ms. Kaski Maskey for their contributions from the planning of the survey to the writing of the report.

Ms. Cynthia Carter, JHU deserve our personal gratitude for the unlimited contribution she has made which led the survey to be a success.

SC/Nepal - Nuwakot District CSVIII:
Midterm Survey Report

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Executive Summary

A midterm rapid knowledge, practice and coverage (KPC) survey was carried out in 14 VDCs of Ilakas Xl, 12 and 13 of Nuwakot District from March 15-19, 1994. The objective of the survey was to measure the health knowledge and practice among mothers with children under 2 years old.

The Child Survival VIII project is implemented by Save the Children US (SC/US), a PVO with US Headquarters in Westport, Connecticut; in close coordination with His Majesty+ Government of Nepal, Ministry of Health and District Health Office of Nuwakot.

This CSVIII project received US $412,248 from USAID through the Bureau for Humanitarian Response/Office of Private and Voluntary Cooperation to implement Child Survival activities from October 1, 1992 to September 30, 1995. SC/US matched with US $137,417. The total budget is US $549,665 over three years.

The survey questionnaire was initially drafted at the PVO Child Survival Support Program (PVO CSSP), The Johns Hopkins University School of Hygiene and Public Health in consultation with SC/Nepal. It was based on a standardized format which USAID requires of all PVO CSVIII projects. The questionnaire was further refined in field tests in country. The field team received a training in 30 cluster sample survey methodology facilitated by the PVO CSSP survey trainer, Cynthia Carter. The entire survey schedule was implemented in three weeks.

Major survey findings include: A 14.4% literacy rate among interviewed mothers. Fifty six percent of children experienced diarrhea in the past 2 weeks. ORS (Jeevan Jal) usage rate was found to be 20%. Complete immunization coverage is 21.6%. Sixteen percent of pregnant mothers attended prenatal clinics. Twelve percent of couples use modem contraceptives.

Fifteen major recommendations developed by the project staff are:

-Assess the performance of community health volunteers in educating and motivating mothers for immunization and other interventions.
Continue disseminating health messages through different groups, such as NFE centers, women's groups, and mothers' groups.
-Collaborate with John Snow International (JSI) to explore ideas on provision of AR1 services.
-Explore ideas on community financing for regular supply of antibiotics.
-Conduct focus group studies to develop specific AR1 education messages.
-Develop promotional activities on Jeevaa Jal, emphasizing the "dehydration aspect" of diarrhea and the importance of giving food during diarrhea.
-Establish sales agents for Jeevan Jal.
-Train traditional healers in the signs and symptoms of dehydration and the use of Jeevan Jal.
-Discuss with DHO the distribution and availability of family planning supplies and service delivery through health posts and obtain supplies from DHO on regular basis.
-Identify health personnel who are qualified to provide depo-provera and train them in providing depo-provera injections. Investigate possibility of training VHWs as well.
-Plan and provide education to mothers on proper nutrition during pregnancy.
-Identify potential channels to disseminate message of three clean birth principles to women who deliver and cut cords by themselves (53%).
-Promote social marketing of Safe Birth Kits.
Conduct workshops for TBAs, CHVs, MCHWs, mothers' groups focusing on the three clean birth principles.
Conduct mass 'IT camps.

I. INTRODUCTION

A. Background

Save the Children(SC)/Nepal initiated a CSVIII project in Ilakas 1, 12 and l3 of Nuwakot district, Nepal in October 1992. The beneficiary population of 40,193 includes 10,893 children under six years of age and 8,569 women between the ages of 15 and 45. SC works with the District Health Office (DHO), Nuwakot to empower families to promote child survival. SC is replicating lessons learned from over twelve years of community development experience in Nepal to create a sustained increased demand in Child Survival services.

This project focuses on sustainability through the strengthening of women's groups and the integration of Child Survival initiatives (EPI, CDD, Maternal Health, Vitamin A, Pneumonia Control, and AIDS Prevention) with a broad range of nonformal education activities, especially literacy and early childhood education and nutrition. Child Survival messages are taught through basic and advanced literacy classes, child care cooperatives, parenting classes, mothers groups and women's savings groups. Child Survival messages are also taught through a CHILD to CHILD program. The project works to strengthen the service delivery system of the DPHO through intensive training for DPHO and health clinic staff, local health volunteers, and community leaders. Support is also provided for mobile health clinics.

The goal of the project is the sustained reduction in infant, child, and maternal mortality and morbidity by empowering families to address their health, educational and developmental needs and by creating an increased demand for improved government health services.

To accomplish this goal by the end of the project (October 1, 1992 - September 30, 1995), Save the Children received $412,248 from USAID matched by $137,417 from SC for a total budget of $549,665 over 3 years.

B. Objectives of the Survey

A population based sample survey is one method of obtaining rates; that is data relevant to denominators, which are and important part of a project's health information system. The data collected from a sample survey can be used for project design, management and evaluation purposes. By restricting the sample to mothers of children less than 24 months of age, repeat surveys can ascertain the project's ability to reach children born during the life of the project, and establish whether the project was successful in communicating to the mothers certain action messages about key Child Survival interventions.

The objectives of the survey are to provide SC/Nepal-Nuwakot district staff with information about the following issues:

- For mothers of children under two years of age, knowledge of the following interventions related to the health of their children: breastfeeding and child feeding practices, vitamin A supplements, management of diarrheal disease, immunizations, maternal care and family planning, and pneumonia control.
- The actual practices of mothers with regard to the interventions mentioned above.
- For children age 12-23 months, the coverage rates for BCG, DPT3, OPV3, and measles vaccines.
- Other caretakers of children who should be targeted for health education action messages.
- Mothers knowledge about the transmission and prevention of HIV/AIDS.

C. Schedule of Activities

Jan. - Feb.	SC staff prepares for the survey, which includes: gathering population based data for the selection of 30 random cluster sites, selecting supervisors and interviewers, determining costs and logistics of both training and conduct of the survey, negotiating adaptations to the generic survey questionnaire, and communication and coordination with the survey trainer prior to her arrival in Kathmandu February 4th.
Feb. 6-9	Final preparation of the survey in Kathmandu, including finalizing the Nepali questionnaire, sample selection, developing the training design, reviewing tabulation tables.
Feb. 10	Travel to the field.
Feb. 11	Preparation for survey training and finalize logistics; draw sample with field staff.
Feb. 12-14	Training of supervisors, interviewers, and field test questionnaire.
Feb. 15-19	Households interviews.
Feb. 20-21	Hand Tabulation of survey data.
Feb. 22-23	Data Analysis and report writing.
Feb. 24	Feedback to SC/Nuwakot staff, DPHO, and the community.
Feb. 25	Travel to Kathmandu.
April	Feedback to USAID/Nepal and MOH

II. METHODOLOGY

A. The Questionnaire

The questionnaire, which contains 59 questions, was designed to collect information from mothers of children under 24 months of age. The questions were based on a standard survey format which USAID requires of all CS VIII projects. The standardized survey instrument was developed by the staff at the PVO Child Survival Support Program (PVO CSSP), with the assistance of US and international experts for the various interventions, and in cooperation with SC/Nepal-Nuwakot field staff. SC/Nepal-Nuwakot, in cooperation with the PVO CSSP Survey Trainer Cynthia Carter, further customized the standardized survey questionnaire making the final questionnaire appropriate to the actual CSVIII projects interventions and the project area.

Questions 2 and 3 ask about the age of the respondent (mother) and her youngest child under 24 months of age; questions 4-6 collect data regarding mother's literacy, employment, and who cares for the child when the mother is away from home; questions 7-21 deal with breastfeeding and other feeding practices; questions 22-23 relate to knowledge of vitamin A and vitamin A rich foods; questions 24-33 refer to mother's response to diarrheal disease and management of the child with diarrhea; questions 34-38 deal with mothers action and knowledge of signs/symptoms of pneumonia; questions 39-44 concern the immunization status of the child; questions 46-57 are about prenatal care, TT status, clean birth, clean practices, and family planning; finally, questions 58-59 ask about mothers knowledge of the transmission and prevention of AIDS.

In some cases, the Nepali questionnaire was translated (verbally) into Tamang when Tamang mothers who did not understand Nepali.

B. Determination of Sample Size

Sample size was calculated with the following formula:

Where a= sample size; z= statistical certainty chosen; p= estimated prevalence/coverage/level to be investigated; q= l-p; and d= precision desired.

The value of p was defined by the coverage rate that requires the hugest sample size (p=.5). The value d depends on the precision, or margin of error, desired (in this case d = .lO). The statistical certainty was chosen to be 95% (z=l.%). Given the above values, the needed sample size (n) determined was:

a = (l.% x l.%) (.5 x .5)/ (.l x .l)
a = (3.84) (.25)/ .Ol, n = 96

It takes much time to randomly select and identify individuals from the survey population, and then perform this selection % times to identify a sample of a = 96. Time can be saved by doing a 30 cluster sample survey in which several individuals within each cluster are selected to reach the required sample size.

However, in order to compensate for the bias which eaters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of p, d, and z above (Henderson, et.al, 1982). In general, when using a 30 cluster sample survey, the sample size used should be approximately double the value a, when:
a = (z x z) (pq)/(d x d). In this case sample size of 240 (8 per cluster) was selected so as to ensure the

minimum of 210 would be obtained.

The estimate of confidence limits for the survey results were calculated using the following formula :

95% confidence limit = p + /- z (square root of {pq/a})

Where p = proportion in population found from survey;
z = statistical certainty chosen (if 95% certainty chosen, that z = 1.96); and a= sample size.

EXAMPLE : If the proportion of children in the survey who were completely and correctly immunized is 37% and n = 297 :

95% confidence limit = .37 + /- l.%
(z = l.%)
1.96 = 37 + /- .03 (34% to 40%)

In other words, we are 95% sure that the actual proportion of children in the survey who are completely and correctly immunized is between 32% and 40%.

C. Selection of the Sample

The sample consisted of 240 women with children O-23 months of age in 14 Village Development Committee (VDC) in Nuwakot district, Ilaka 1, 12 and 13. Eight households were selected in each of 30 randomly selected wards (cluster sites) following the process described in The EPI Coverage Survey training manual (WHO, Geneva, October 1988).

Before the survey teams reached the designated wards, the clusters were subdivided further into hamlets. Hamlets are traditional units in which population based data is not available. One hamlet was randomly selected as the community within each ward to be surveyed. The initial household surveyed within the hamlet, as well as the direction from the initial household, was also randomly selected.

D. Training of Supervisors and Interviewers

Save the Children staff pre-selected thirteen supervisors; twenty five interviewers were hired. Interviewer qualifrcatioas included SLC pass (high school equivalent). Thirty local women were interviewed for the twenty six open positions of thirty, twenty six were selected but one woman dropped out before attending training.

The training of supervisors took place in one half day. The training of interviewers took place in two and one half days. The first half day of training of supervisors was conducted by the PVO CSSP Survey Trainer; days two and three of training were conducted by SC staff with facilitation by the PVO CSSP Survey Trainer. The PVO CSSP Survey Trainer conducted sessions in Nepali and English.

The supervisors' training sessions included sample size, selection of 30 random cluster sites, selecting first household for interview, identifying supervisor and interviewer responsibilities, review of the questionnaire, how to code responses, interview methods, and good supervision.

The interviewers' training session included review of the questionnaire, how to code responses, and interview methods. Good and bad interview techniques were demonstrated by four (two teams of two) SC staff. An additional session demonstrated how to properly record information on immunization, TT, and antenatal cards.

It was determined that the interviewers needed a heavy focus on practice interviewing. Therefore, sessions on sample size calculations and drawing the 30 cluster sample were not reviewed in depth with the interviewers. Random selection of the hamlet and household was reviewed in detail. The SC CSVIII Deputy Public Health Coordinator, Naramaya Limbu, conducted the training of interviewer sessions with the assistance of Project Coordinator, Rabindra Thapa.

The PVO CSSP Survey Trainer facilitated the practice interview sessions and proper delivery of some of the more difficult questions. The session to find out date of birth by Tibetan calendar was conducted by NPE Coordinator, Rajeadra Lama, with assistance by Bed Lama.

The foal day of the training began with a field test of the survey questionnaire. Team assignments were given to the interviewers. Each team consisted of two interviewers and one supervisor. Eight nearby villages, which did not fall into the survey sample, were selected for the field test. Each interviewer completed two interviews with mothers of children O-23 months old. AU questionnaires were checked by the PVO CSSP Survey Trainer and Project Coordinator. In an afternoon feedback session, each interviewer reviewed their coding errors, difficulties experienced in the field and general impression of the day's activity. Complex words and difficulty recording information from the immunization card were two main problems experienced by the interviewers during the field test.

On the first day of deployment, more skilled interviewer teams were sent early in the morning and those interviewers who needed more practice left in the afternoon.

E. Method for Data Tabulation and Analysis

A team of sixteen persons, working in pairs, tabulated the data by hand. Tabulators were Save the Children staff and five interviewers. Main tabulation took two days. On day three, two teams analyzed weaning practice and prolonged breastfeeding data. Each question from the survey questionnaire had one or more tables that coincided with the question. Tables consisted of frequency distribution and cumulative percent columns.

Tabulators received a short training from the PVO CSSP Survey trainer in tabulation technique. The PVO CSSP Survey Trainer and SC project coordinator supervised the hand tabulation.

F. Budget

costs •

		Rs.	US $
1.	Casual Labor :		
	Supervisors (1 DHO staff X 14 days)	1794.00	35.88
	Enumerators	21,500.00	430.00
	Porters	5,412-W	108.24
2.	Perdiem :		
	Dy. PHCs (2 X 16 Days X Rs.125/ = per day)	4,000.00	80.00
3.	Training snacks :	824.00	16.54
4.	CSSP Survey Trainer (Food) :		
	Nuwakot	1,045.00	20.90
5.	CSSP Survey Trainer (Accommodation):	10,000.00	200.00
6.	Reproduction of report :	Pending	
7.	Total (in-country expenses)	44,578.00	891.46
8.	Total (international travel)	1,15,00.00	2,300.00

Costs does not include those expended in KTM vis: sleeping bags, flash light, printing, clipboards etc.
Grand total does not include cost for salary of survey trainer and administrative expenses paid by PVO CSSP.

G. Feedback

The feedback session participants were a district public health official, health post staff, the Vice Chairman of different wards, school teachers, community leaders and Save the Children/US Nuwakot field staff.

A summary of the results of the CSVIII midterm survey was presented on March 24, 1994, at Samundratar. Eighteen people participated in the feedback session. The session was conducted from 1:30 p.m. to 3:30 p.m. The findings were presented by the CSVIII project coordinator and the Deputy Public Health Coordinator.

The summary of results highhghted important findings from each of the intervention modules on the questionnaire. The participants actively participated in the discussion with many questions and comments. Specifically, the Vice Chairman raised questions about the Depo-provera injection related to the information needs of the users as well as side effects from the Depo injection.

Participants showed concern about the results related to the percentage of children with diarrhoea in the last two weeks. Use of Jeevan Jal was not seen as satisfactory. The group suggested giving more emphasis to educational efforts and to use NFE classes to promote Jeevan Jal.

The presentation of findings was followed by a review of the Child Survival interventions and strategies.

III. RESULTS

Mother's Age:

Range: 17 - 44
Mean: 27.9 years
Medium: **26 years**

Child's Age:

The children's ages were truncated (i.e. rounded down to the nearest whole number of months, e.g. 29 days = 0 months).

Age	**Freq**	**Percent**	**Cumulative %**
0	***l3***	5.5	5.5
1	14	5.9	11.4
2	14	5.9	17.3
3	11	4.6	21.9
4	7	2.9	24.8
5	8	3.3	28.1
6	13	5.5	33.6
7	10	4.2	37.8
8	13	5.5	43.3
9	12	5.0	48.3
10	8	3.4	51.7
11	16	6.7	58.4
12	17	7.2	65.6
13	6	2.5	68.1
14	5	2.1	70.2
15	9	3.8	74.0
16	9	3.8	77.8
17	5	2.1	79.9
18	13	5.5	85.4
19	6	2.5	87.9
20	6	2.5	90.4
21	9	3.8	94.2
22	7	2.9	97.1
23	5	2.1	99.2

Total # children: 236
Mean age: 10.05 months
Medium age: 10 months

Mother's Education:

14.4% of mothers are literate.
85.1% of mothers did not go to school.
8.9% (21) of mothers have never been to school, but caa read and write.
3% of mothers had studied at lower secondary school levels or above.

Child's caretaker:

84.7% of mothers leave their children at home while they work outside the home.
42.4% of mothers reported leaving their children with other relatives.
36.9% of mothers reported leaving their children with older sisters/brothers.
22.9% of mothers took their children with them when they went for work.
9.7% of mothers left their children alone at home.
5.5% of fathers look after their children while the mother is away for work.

Feeding Prac tices

Breasfeeding:

97.5% of mothers were currently breastfeeding their c2 year old children.
41% of mothers had breastfed their babies within one to eight hours after delivery.
33% of mothers reported breastfeeding within one hour of delivery.
25 of 27 mothers reported breastfeeding their 20-23 month old children.

Weaning Food:

Out of 52 mothers, 12 introduced supplementary weaning food to their children between the age of O-3 months.
Out of 44 mothers, 41 introduced supplementary weaning food to their 5-8 month old children.
Supplementary weaning food introduced to the children between the ages of 4-6 months is presented on the following table:

Are you giving child . ...?	4-6 months # %	Total # of mothers=28
Semi-solid food	20 71.4%	
Fruits	5 17.9%	
Leafy green vegetables	8 28.6%	
Meat/fish	3 10.7%	
Pulses/beans/peanuts	7 25%	
Eggs/curd	6 21.4%	

39.4% of mothers introduced supplementary weaning foods before the age of 4 months.
33.5% of mothers introduced supplementary weaning food to their children between the age of 4-6 months.
88.2% of mothers mixed additional fat into their children's food.

Mothers reported that the following food items should be the supplementary weaning food:

FOODS	% of mothers reported
Addition of fat in food	52.0
Green leafy vegetables	38.9
Fruits	16.9
Meat/fish	19.9
Other foods	17.7
Do not know	4.0

Vitamin A:

91.5% of mothers did know that vitamin A prevents night blindness.
22.5% of mothers reported that green leafy vegetables are sources of vitamin A.
16.1% reported yellow fruits as sources of vitamin A..
17 mothers reported meat/fish as a source of vitamin A.
4 mothers reported that egg yolk contains vitamin A.
48 of the 169 children between age 6-23 months received the first dose of vitamin A and 8 children received the second dose of vitamin A.

Diarrhea:

56.3% of mothers reported their child had diarrhea within the last two weeks.

Feeding practice during diarrhea: (Percentages are based on 133 mothers reporting that her child had an episode of diarrhea.)

Breastfeeding:

8.3% of mothers reported breastfeeding MORE than usual during diarrhea.
74.4% of mothers reported breastfeeding the SAME as usual.
16.4% of mothers reported breastfeeding LESS than usual.

Fluids:

8.2% of mothers reported giving MORE fluids than usual during diarrhea.
47.7% of mothers reported giving the SAME as usual.
21.1% reported giving LESS than usual.
22.9% reported STOPPING fluids completely during diarrhea.

The remainder of mothers reported that they were exclusively breastfeeding.

Solid/Semi-solid foods:

5.3% of mothers reported giving MORE foods during diarrhea.
40.7% of mothers reported giving SAME as usual.
39.8% of mothers reported giving LESS than usual.
14.1% of mothers reported STOPPING foods completely.

ORE (Treatments given)

33.0% of mothers did not give any treatment for diarrhea.
20.3% of mothers reported giving JEEVAN JAL (ORS) during diarrhea.
4.5% of mothers reported giving other fluids.
13.5% of mothers reported treating their child's diarrhea with drugs/antibiotics.

Seeking advice or twatment:

66 of 133 mothers sought advice/treatment.
Of these, 18.2% of mothers reported seeking advice/treatment from MCH mobile clinics.
15 mothers sought advice/treatment from the hospital or health post.
8 mothers reported seeking treatment from drug shops.
515% of mothers reported seeking advice/treatment from traditional healers.
25.7% of mothers reported seeking advice/treatment from relatives/friends/neighbors.
3 of 66 mothers reported seeking advice/treatment from TBAs and VHWs.

What signs/symptoms cause mothers to ***seek advice/treatment:***

9 out of 236 mothers recognized dry mouth, sunken eyes and decreased urine as signs to seek advice or treatment during diarrhea.
13.9% of mothers reported that they do not know the signs/symptoms of diarrhea for which to seek advice.
49.6% of mothers reported prolonged diarrhea as a symptom for which to seek advice/treatment.
7.2% of mothers reported blood in stool as a symptom.
13.1% of mothers reported loss of appetite.
13.9% of mothers reported weakness.
18.2% of mothers reported vomiting.
52.5% of mothers reported fever.

What actions should be taken by mothers for child's diarrhea:

5 of 236 mothers reported that they should give fluids more than usual.
5 mothers reported that they should give more frequent, smaller meals during diarrhea.
33.0% of mothers reported that they should prepare and give Jeevan Jal to drink during diarrhea.
10.2% of mothers reported that they should give a salt sugar solution.
7.6% of mothers reported that they should give more fluids immediately.
16.1% of mothers reported that they should go to the hospital/health post for their child's diarrhea.
3 mothers reported that they should stop giving fluids.
13.1% of mothers reported that they do not know what they should do when their child has diarrhea.

Recovery from Diarrhea:

159 mothers know appropriate feeding practices after diarrhea, i.e., smaller and more frequent meals, more high-energy foods, and more food than usual.
25 mothers reported that they do not know what they should do when their child is recovering from diarrhea.

Immunization:

65.2% of mothers reported that their children have received immunization.
66.6 of mothers did not know the right age at which to give the child measles vaccine.
33.4% of mothers interviewed said that the right age for measles vaccine is 9 months.

Maternal Immunization:

173% of mothers interviewed said that TT will protect both mother and child from tetanus.
73.7% of mothers interviewed did not know what TT protects against.
19.9% of mothers interviewed said that she needs two or more doses of TT.
68.2% of mothers interviewed said they "did not know" the proper number of TT shots needed.

Child Immunization:

47.4% of mothers could show their EPI card.
17.7% of mothers had lost their EPI card.
34.7% of mothers never had a card.

Summary of immunization coverage (I2 - 23 months)

23% of children had DPT 3 coverage
23% of children had Polio 3 coverage
38% of children had BCG coverage
21% of children had measles coverage
DPT Dropout = 42%
Polio Dropout = 42%
Overall Dropout = 43%
Complete coverage = 21%

Acute Respiratory Infection (ARZ)

50.4% (119 out of 236 mothers) reported that their child had cough and difficult breathing during the last two weeks.
93.2% (111 out of 119 children) had rapid and difficult breathing.
53.2% (59 out of 111 mothers) sought treatment for their children.
Of the 59 mothers seeking treatment, 50.9% of mothers went to the health post, hospital, or MCH mobile clinics.
153% consulted medical shops or private clinics.
3.4% consulted VHWs.
52.5% consulted traditional healers.
24% of all mothers do not have knowledge of ARI's signs and symptoms.
39.4% of mothers reported that they will refer their children to health institutions if they have rapid and difficult breathing.
10% of mothers reported that they will refer children with AR1 if they have an indrawn chest.

Maternal Health:

26 mothers could show their antenatal card.
12 mothers reported losing their antenatal card.
197 mothers reported that they never had a card.

Antenatal care:

57.6% of the 26 mothers with an antenatal card had at least one antenatal visit.
42.3% of the mothers had two or more visits.

Maternal TT:

56 mothers could show TT cards.
27 mothers reported losing their TT cards.
153 mothers reported that they never had a card.
Of the 56 mothers with TT cards, 30 mothers received at least one dose of TT.
25 mothers received two or more doses of TT.
One mother did not receive TT.

Family Planning:

14 mothers reported being pregnant at the time of the survey, so were not asked the family planning questions.
Of 222 mothers who were not pregnant, 23 desire a pregnancy within the next 2 years and 18 did not know if they desired a pregnancy.
Of the 180 mothers who did not want to be pregnant, 12.2% (22) are using family planning.
Of these 22 couples, one has had a laparoscopy/minilap, 14 have had vasectomies, two are takiig oral contraceptive pills, two are using condoms, two are receiving depo-provera injections, and one couple is practicing abstinence.

Eating practice during pregnancy:

54.2% of mothers reported eating the same as usual.
10.5% of mothers reported eating more than usual.
34.3% of mothers reported eating less than usual during pregnancy.

Delivery assistant - cord cutting practice:

53.4% of mothers reported that they cut the child's cord by themselves.
29.3% of mothers reported that family members cut the cord.
7 mothers reported that the cord was cut by an untrained TBA.
7 mothers reported the cord was cut by a trained TBA.
2 mothers reported the cord was cut by health personnel.

Knowledge of Clean Birth Practices:

5 of 236 mothers correctly reported the three clean birth practices (clean hands, clean surface, clean cutting tool).
39 of 236 mothers could identify two of the three clean birth practices.
80 of 236 mothers (33.9%) identified one of the three clean birth practices.
47.4% of mothers incorrectly stated the clean birth practices or did not know them.

Knowledge of AIDS Tmnsmission and Prevention:

50 mothers identified sexual contact as a mode of AIDS transmission.
24 mothers reported that AIDS is transmitted through unsterile needles and syringes.
16% of mothers reported that AIDS is transmitted through infected blood.
171 mothers did not know how AIDS is transmitted or reported shaking hands, handkerchief/cloth, or mosquito bite as modes of transmission.

10 mothers reported that condoms prevent AIDS transmission.
32 mothers reported that AIDS transmission can be prevented by not having multiple sex partners.
16 mothers said not having sex with an unknown person can prevent the transmission of AIDS.
8 mothers reported abstinence as a way to prevent the transmission of AIDS.
16 mothers said AIDS can be prevented by not using already used (unsterile) syringes and needles.
177 mothers did not know any method to prevent the transmission of AIDS.

IV. DISCUSSION AND RECOMMENDATIONS

Immunization:

Complete immunization coverage for BCG, DPT, measles and polio among children between 12-23 months is 21%, which shows an increasing upward trend. However, dropout rates for DPT and polio is 42%. Forty-seven percent of mothers could show EPI cards. Almost three-fourths (73.7%) of mothers did not know the reasons for TT immunization. Only 19.9% of mothers knew that more than two doses of TT were needed for protection against tetanus.

Recommendations:

Assess performance of community health volunteers in educating and motivating mothers for immunization.
Continue disseminating EPI messages through different groups, such as NFE centers, women's groups, and mothers' groups.
Motivate and educate mothers not to loose EPI cards.
Conduct focus group studies to identify reasons for dropout.
Develop IEC materials on EPI.
Continue TT mass camps to improve TT coverage.

Acute Respiratory Infections:

Slightly less than half (53.2%) of the 111 mothers and children with ARI sought treatment. The majority of them (52.5%) still rely on traditional healers, partly because of traditional beliefs and partly because of the unavailability of drugs, 49.4% of the mothers who were interviewed knew the signs of AR1 which require referral.

Recommendations:

Collaborate with John Snow International (JSI) to explore ideas on provision of AR1 services.
Explore ideas on community financing for regular supply of antibiotics.
Conduct focus group studies to develop specific AR1 education messages.
Emphasize preventive aspect of ARI.
Continue giving AR1 messages through NFE centers and other groups.

Breasrfeeding:

The midterm survey shows that 97.5% of the women breastfed their <2 year old children. 92.6% of the mothers practiced prolonged breastfeeding, which is a good indicator for child survival. 33% of the mothers started breast feeding within one hour of childbirth.

Recommen&tions:

Develop IEC material on breastfeeding.
Encourage early breastfeeding and emphasize immunity benefits of colostrum.

Weaning Practice:

Mothers' knowledge and practice regarding the introduction of supplemental foods are not adequate. 91.1% mothers reported giving additional food to their child from age of 5-8 months. 77.7% of mothers did not give other foods, but exclusively breastfed their child, which is a good practice. 23% of the mothers gave additional food to their child. 52% of the mothers give ghee and oil as supplementary food; 39% give green vegetables, 17%, fruits, and 19%, meat and fish.

Recommendations:

Encourage exclusive breastfeeding for O-3 month old children.
Emphasize birth spacing through IEC and educational activities.
Develop and provide an area specific program on maternal health and child care.

Vitamin A:

The majority of mothers do not know about vitamin A. Only 8.4% reported knowing that vitamin A prevents night blindness.

Recommen&tions:

Promote knowledge of vitamin A in different sectors.
Disseminate IEC messages through alternative channels, such as including vitamin A messages in mobile clinic messages.

Diarrhea:

Data shows a 56.3% diarrhea prevalence (due to season). The majority of the mothers, 74%, give breast milk during diarrhea. 20.3% of the mothers used Jeevan Jal to treat diarrhea, which shows a growing trend. The majority of the mothers who sought advice or treatment (51.5%) did so from traditional healers.

Recommendations:

Develop promotional activities on Jeevan Jal, emphasizing the "dehydration aspect" of diarrhea and the importance of giving food during diarrhea, since poor feeding can result in weight loss.
Identify whether Jeevan Jal is readily available.
Establish sales agents for Jeevan Jal.
Train traditional healers in the signs and symptoms of dehydration and the use of Jeevan Jal.

Liferacy:

There is a slightly upward trend in literacy rates among women. 14.4% of the mothers are literate, compared to the baseline survey of 6.6%.

Recommendations:

Give attention to formal education and mass education.
Develop program oriented to educating target groups of lower casts or particular ethnic groups.

Caretaker:

40% of mothers leave their children to other relatives. 36% children are taken care of by their elder brothers and sisters.

Recommendations:

Develop methods to disseminate health messages to the caretakers as well as the mothers.
Continue the child to child program, teaching about proper child care.

HIV/AIDS:

Most of the mothers (72.4%) do not have knowledge about HIV/AIDS and its transmission. Only 4.2% know to use a condom for the prevention of AIDS transmission.

Recommendations:

Emphasize IEC messages on AIDS and disseminate more widely, through mothers' groups, non-formal education, etc.

Maternal Health:

There is an upward trend in the utilization of maternal health services. The knowledge of the three clean birth principals, as well as accessibility of family planning services, needs to be improved.

Recommendations:

(a) Family planning services:

Discuss with DHO the distribution and availability of family planning supplies and service delivery through health posts.
Revise and reestablish a channel for distributing family planning supplies. Obtain supplies from DHO on regular basis.
Identify health personnel who are qualified to provide depo-provera and train them in providing depo-provera injections. Investigate possibility of training VHWs as well.
Establish a regular system to provide temporary contraceptive methods through mobile clinics.
Provide education on birth spacing.

(b) Antenatal care:
Train MCHWs in maternal health care.
Plan and provide education to mothers on proper nutrition during pregnancy.

(c) Delivery services:
Identify potential channels to disseminate message of three clean birth principles to women who deliver and cut cords by themselves (53%).
Promote social marketing of Safe Birth Kits.
Conduct workshops for TBAs, CHVs, MCHWs, mothers' groups focusing on the three clean birth principles.

(d) Maternal TT: Conduct mass TT camps.

V. LESSONS LEAFWED

Training:
Two days of training for interviewers are insufficient for adequate capability in interviewing techniques or recording information from immunization cards.
Training should include more about:
where to mark the appropriate answer (particularly if the answer given is not word for word),
more discussion on cross checking weaning practice questions with feeding practice during diarrhea (X25,26, 27).

Communication:
Communication difficulties in some areas can be reduced by:
using a bilingual mediator after giving them an orientation,
hiring interviewers who are bilingual,
becoming familiar with local terms.
Complex technical terms should be simplified.

Strengths:
Having supervisors (staff) who had previously conducted the baseline survey strengthened the quality of the survey.
Excellent planning/deployment and logistics in Kathmandu and Nuwakot gave impetus for the survey.
Team decision-making was very effective.

VII. BIBLIOGRAPHY

1. Save the Children/Nepal Field Office, Child Survival VIII proposal, December 1991.

2. Save the Children/Nepal Field Office, Child Survival VIII Detailed Implementation Plan, April 1, 1993.

3. PVO Child Survival Support Program, JHU, KPC Survey Manual and Trainers Guide, November 1993 (DRAFT).